AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett

PATIENT'S CONSENT FOR SURGICAL FRENULA REMOVAL OR FRENECTOMY

Diagnosis: After a careful oral examination and study of my dental/oral condition, my periodontist has advised me that I will need a surgical frenectomy or frenula relocation for one or more of the following reasons:

- ☐ aberrant location resulting in increased space between teeth
- ☐ to facilitate orthodontic closure of spaces between teeth due to location of frenula
- ☐ to relieve tension on the gum therefore reducing the possibility of future recession/ bone loss
- ☐ to facilitate sleep apnea therapy

Recommended Treatment: In order to treat this condition, my periodontist has recommended surgical frenectomy or frenula relocation to improve the prognosis of the affected teeth. I understand that a local anesthetic will be administered. I further understand that antibiotics and other substance may be applied to the healing sites and/or prescribed systemically.

Surgical Phase of Treatment: With surgical frenectomy or frenula relocation, the frenula or muscle attachment will be removed/relocated. A suture(s) may be placed along with a dressing.

Expected Benefits: Surgical frenectomy or frenula relocation is expected to extend the prognosis of the treated teeth due to reduced tension from the frenula on the gum tissue. This will help prevent further recession at the treated tooth/teeth. Further benefits include facilitation of orthodontic closure of spaces as a result of frenula presence, as well as soft tissue graft placement if performed.

Principle Risks and Complications: I understand that complications may result from surgical frenectomy or frenula relocation, drugs, and anesthetics. These complications include, but are not limited to: post-surgical infection, bleeding, swelling and pain, facial discoloration; transient but occasional permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injury or associated muscle spasm; transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet and acidic foods, cracking, stretching or bruising of the mouth, restricted ability to open the mouth for several days or weeks, tightness of lips to gums, impact on speech, allergic reactions, injury to adjacent teeth; delayed healing and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

Alternatives to Suggested Treatment: Alternative treatment includes – No treatment which may result in future recession/ bone loss.

Necessary Follow-Up Care and Self Care: I will need to come to my appointments following my surgical frenectomy or frenula relocation so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of the procedure upon completion of healing. Smoking or alcohol consumption may adversely affect gum healing and may limit the successful outcome of the surgical procedure. I know that it is important to 1) abide by the specific prescriptions and instructions given by the periodontist and to 2) see my periodontist and dentist for periodic examination and prevention treatment. Maintenance also may include adjustment of prosthetic appliances. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure. I have received written pre-surgical and post-operative care instructions.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences a periodontist cannot predict certainty of success. There exists the risks of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public without my permission.

I HAVE BEEN FULLY INFORMED OF THE SURGICAL PROCEDURE, BENEFITS, AND RISKS AND ASSOCIATED PROCEDURES. I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND HAVE HAD ADEQUATE TIME TO REVIEW THIS DOCUMENT. I WILL COMPLY WITH THIS DOCUMENT AND MY PERIODONTIST/STAFF HAS ANSWERED ALL MY QUESTIONS TO MY SATISFACTION.

Patient's Printed Name	Signature	Date
Witness Printed Name	Signature	Date
Doctor's Printed Name	Signature	Date