AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett

PATIENT'S CONSENT FOR SURGICAL SUPRACRESTAL FIBEROTOMY

Diagnosis: After a careful oral examination and study of my dental/oral condition, my periodontist has advised me that I will need a surgical supracrestal fiberotomy for the following reasons:

Relieve tension of the gingival or gum tissues from the teeth to prevent orthodontic relapse or shifting of the teeth during the retainer phase of orthodontic care (after removal of braces).

To facilitate orthodontic movement of teeth by relieving tension of the gingival or gum tissues on the teeth during active orthodontics (while braces are still on).

Occasionally, during or after orthodontic care there is tension between the teeth and gums resulting from gum and periodontal tissues which are stretched as the teeth are moved into a more ideal position. We know this happens from many studies of gum tissues during orthodontic care. In these studies, the gums were marked prior to tooth movement. When the teeth were rotated, the marked tissues also rotated. When the force was removed, the gums and the teeth relapsed to their original position. To prevent the relapse, the gum tissue was surgically and temporarily separated from the tooth. This allowed the gum tissue to pull back to its original position leaving the tooth without tension and preserving the tooth in an ideal location. Some teeth cannot be moved to their ideal position due to tension of the gum and periodontal tissues. These teeth are treated during active orthodontic tooth movement (while braces are on) with supracrestal fiberotomy to allow complete tooth movement to their ideal location.

Recommended Treatment: In order to treat this condition, my periodontist has recommended surgical supracrestal fiberotomy to improve the prognosis of the affected teeth and orthodontic care. I understand that a local anesthetic will be administered. I understand that antibiotics and other medications for post-operative discomfort may be prescribed.

Surgical Phase of Treatment: With surgical supracrestal fiberotomy, an incision will be made between the tooth root and the gum and periodontal tissues to separate these tissues temporarily to remove tension of these gum and periodontal tissues on the treated teeth.

Expected Benefits: Surgical supracrestal fiberotomy is expected to help prevent relapse or shifting of the treated teeth due to reduced tension from the gum tissue on the treated teeth. This treatment is meant to be additive to conventional retainers and such appliances designed to prevent orthodontic relapse or shifting of the treated teeth. Failure to follow the orthodontist's recommendations will allow relapse, regardless of the supracrestal fiberotomy procedures.

Principle Risks and Complications: I understand that complications may result from surgical supracrestal fiberotomy, 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 occasional permanent increased tooth looseness, periodontal or gum tissue recession, 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 reversible.

Alternatives to Suggested Treatment: Alternative treatment includes – No Treatment. However, orthodontic relapse is quite likely if treatment is not completed.

Necessary Follow-Up Care and Self Care: I understand that it is important for me to continue to see my dentist and orthodontist and to abide by the specific prescriptions and instructions given by my periodontist. I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come to my appointments following my surgical procedure 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 have received written pre-surgical and post-operative care instructions. 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.

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, 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.

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Patient/Guardian Printed Name	**Patient signature**	**Date**
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Witness Printed Name	**Witness signature**	**Date**
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Doctor Printed Name	**Doctor signature**	**Date**