Festina Lente

Integrative Periodontology and Implant Center

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CONSENT FOR CROWN LENGTHENING SURGERY

____ I hereby authorize
Patient Name

Sofia Petrov DDS, MSD, and any associates to perform crown lengthening surgery on

tooth/teeth numbers: ____.

DIAGNOSIS: When a tooth is fractured or decay extends below the gum line, the bone and gum need to be reduced in size around the teeth in order to get access to remove and restore the cavity, or to fix the tooth and place a filling or crown past the fracture. In order for the gum to heal against the tooth in a healthy manner there must be 3 millimeters of healthy tooth between the margin of a filling or crown and the crest of bone which supports the tooth. This allows for proper attachment of the gum to the tooth. In the case of a gummy smile, the gums need to be reduced in size, so the teeth have a more normal appearance.

RECOMMENDED TREATMENT: After an examination and study of my dental condition, the doctor has advised me that I would benefit from a crown lengthening surgery. Local anesthetic will be administered as part of the surgery, the gum will be trimmed and pulled away from the teeth to permit better access to the roots and jawbone. The gum tissue and bone will be reshaped. The gum will then be sutured back closer to the new bone level, and a periodontal dressing may be placed. The surgery will make it look like the gum receded, making the teeth look longer. Some space between the teeth can be expected.

EXPECTED BENEFITS: The purpose of crown lengthening surgery is to provide access for the dentist to correctly restore the tooth or teeth, as better access and visualization of the area are needed. The surgery is intended to help me keep my tooth/teeth in the operated area.

The doctor has explained to me the treatment and the anticipated results of the treatment. I understand this is an elective procedure and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives, including 1) No treatment – if no treatment is done, the dentist may not be able to place a restoration; 2) extraction of the tooth or teeth involved. I also understand that crown lengthening surgery has a very high success rate, but the doctor has not guaranteed or warranted a perfect result.

POTENTIAL RISKS: The doctor has explained to me that there are certain potential complications or risks that could occur in relation to this procedure. These include, but are not limited to: post-surgical infection, bleeding, swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to fully open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, and transient (or on occasion permanent) increased tooth looseness, tooth sensitivity to hot cold, sweet, or acidic foods. The exact duration of any complication cannot be determined and could be irreversible.
There is no method that will accurately predict or evaluate how the gum and bone will heal before a surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory.

FOLLOW-UP AND SELF-CARE: I understand that it is important for me to continue to see my regular dentist for routine dental care, as well as to have the crown lengthened tooth/teeth restored with a filling or crown after the surgery has healed (usually approximately 3 months), if that is needed.

I have informed the doctor of any pertinent medical conditions I have, known allergies, and medications I am taking (including over the counter medications, vitamins, supplements, and herbs.) I have also informed the doctor of any present or prior head or neck radiation therapy, and any present or prior use of bisophonate medications (such as Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®).
I understand that I need to schedule and attend all post-op appointments so that healing may be monitored. I understand that tobacco use, excessive alcohol intake, or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery.

PUBLICATION OF RECORDS: I authorize photos, slides, x-rays, or any other viewing of my care and treatment during or after its completion to be used for either the advancement of general dentistry or in promotional materials. My identity will not be revealed to the general public.

COMMUNICATION WITH INSURANCE COMPANY, MY DENTIST, OR OTHER MEDICAL/DENTAL HEALTH PROVIDERS: I authorize sending correspondence, reports, chart notes, photos, x-rays,

and other information pertaining to my treatment before, during, or after its completion with my insurance carriers, my dentist, and any other health care provider I have who may have a need to know about my dental treatment.

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above or referral to a specialist. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary.

I understand that the medications, drugs, anesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

Please do not hesitate to ask the doctor or the staff if you have any questions.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Date

Printed Name of Patient, Parent, or Guardian

Signature of Patient, Parent, or Guardian

Date

Printed Name of Doctor

Signature of Doctor