Festina Lente

Integrative Periodontology and Implant Center

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CONSENT FOR FRENECTOMY

_____ I hereby authorize
Patient Name

Sofia Petrov DDS, MSD, and any associates to perform frenectomy.

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of abnormal frenum attachment (similar to a ligament) near the gum line about some of my teeth. I understand that this condition may result in recession of the gum tissue over the affected teeth. I understand that it is important to have a sufficient width of gum (attached gingiva) around the base of the teeth (at the gumline) such that it maintains a seal of the gum to the teeth and thereby prevents bacterial invasion under the gum with subsequent inflammation. I understand that where there is insufficient attached gingiva (gum), bacteria and food can become lodged under the gumline and this may result in further recession of the gum or localized infection (gum abscess). I also understand that if this condition is on the back side of my lower front teeth it may be involved with my normal tongue use resulting in further recession.

PURPOSE OFFRENECTOMY SURGERY: I have been informed that the purpose of this surgical procedure is to release and relax this abnormal frenum attachment so as to prevent the likelihood of future gum recession. I understand that this will not reverse the recession (if any) that now exists in the area of abnormal frenum attachment.

SUGGESTED TREATMENT: It has been suggested that the frenectomy surgery be performed in areas of my mouth where I have abnormal frenum attachment. It has been explained that this is a

surgical procedure involving an incision in the gum or mucosa in the area of the frenum and it repositioning further away from the gumline.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) the use of other plastic surgical procedures to attain a similar result; (2)no treatment, with the expectation of chronic inflammation resulting in the advancement of recession which is commonly associated with increased sensitivity of the teeth to temperature extremes and other irritants, increased risk of decay in root surfaces exposed by the recession and possibly the premature loss of teeth; (3) attempts to insulate teeth to control sensitivity by placing fillings in or on root surfaces with the expectation of further recession as a result of this procedure; (4) non-surgical scaling of tooth roots and lining of the gum (root planing and curettage) with the expectation that this will result in only a partial and temporary reduction of inflammation and infection, will not stop recession and will require more frequent professional care, and may result in the worsening of my condition and the premature loss of teeth; (5) extraction of teeth involved with recession and a lack of attached gum tissue.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infection or further bone loss or gum recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to, performance of another plastic surgical procedure to attain a similar result, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I also understand that aerobic exercise can cause the loss of a clot with bleeding and possibly reduced success to the outcome of this surgical procedure. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of surgery.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video recording and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful healing outcome of my surgery. I know that it is important 1) to abide by the specific prescriptions and instructions given by my doctor and 2) to see my doctor and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to connective tissue graft surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

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

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Date Printed Name of Patient, Parent, or Guardian

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Signature of Patient, Parent, or Guardian

_____ _____

Date Printed Name of Doctor

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Signature of Doctor