Patient's consent for Crown lengthening surgery

This is an explanation of your need for cosmetic crown lengthening surgery, the procedure and post-operative care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation with Dr. Obiechina, and we obtained your verbal consent to undergo the treatment planned for you. Please read this document that repeats issues we discussed in their entirety and provide the appropriate signature on the last page. Please ask us to clarify anything that you do not understand. We will answer any of your questions.

Purpose of Crown lengthening surgery: I have been informed that I have a tooth related condition in which an inadequate amount of tooth surface is present for optimal restoration with crowns ("caps") or veneers. The health of my gums and bony support of my teeth will likely be affected if adequate tooth structure is not made available prior to restoration. If untreated, restoration of this area can cause me to have periodontal disease and may result in the loss of my teeth and other adverse consequences. The purpose of this procedure is to elongate the crown of my tooth, by recontouring my gums and bone to the extent possible and to make oral hygiene and professional maintenance more effective.

Recommended treatment: In order to treat this condition my periodontist has recommended gum surgery in which gum and a slight amount of bone will be removed from around the affected tooth or teeth. I further understand that a local anesthetic and sedation may be used as part of this treatment and that antibiotics and/or analgesics may be prescribed.

Risk related to the Procedure: Risk related to cosmetic crown lengthening surgery might include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lips, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, and shrinkage of the gum upon healing.

Risk related to anesthetics: These risks might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of infection of the anesthetics.

Alternatives to the Procedures: These may include: (1) no surgical treatment with the possible worsening of my gum and bone condition; (2) extraction of teeth involved; (3) no treatment with crowns or veneers for those teeth involved; (4) orthodontic tooth movement.

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 my case. There exist the risk of failure, relapse, selective re-treatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement despite of care.

Consent to unforeseen conditions: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include but are not limited to: extraction of hopeless teeth to enhance healing of the adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all 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 effect gum healing and may limit the successful outcome of my surgery. 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 following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report the outcome of surgery upon the completion of healing.

Supplemental records and their use: I consent to photography, filming, 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

Patient's endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after careful consideration, I give my consent for the performance of any and all procedures related to presentation by the doctor or as prescribed in this document.

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Patient's Signature (Signature of Parent or Legal Guardian) Date_____

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Signature of Doctor Date_____

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Signature of Witness Date_____