Consent for Crown Lengthening Surgery

Diagnosis: When a tooth is fractured or decay extends below the gum line, the bone and gum needs 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', my gums need to be reduced in size so my teeth have a more normal appearance.

Recommended Treatment: After an examination and study of my dental condition Dr. _____ has advised me that I would benefit from a crown lengthening surgery. Local anesthetic (commonly called novocaine) 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 *like a plaster pack) might be placed. The surgery will make it look like the gum receded, making the teeth look longer and have spaces between them are expected since we are trying to get better access for my dentist to fix the tooth.

Expected Benefits: The purpose of a crown lengthening procedure is to give access for my 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 or teeth in the operated area.

Principal Risks and Complications: Some patients do not respond successfully to crown lengthening periodontal surgery. Unforeseen conditions may call for a modification or change from the anticipated surgery plan. These may include, but are not limited to, 1) extraction of the tooth or teeth that are to be crown lengthened if they are found to be non-restorable (if a crown or filling cannot be done due to a very deep cavity or fracture), or 2) termination of the procedure prior to completion of the procedure as originally outlined.

Other things in the future, such as accidents, root canal problems, tooth decay, periodontal disease, etc. could also cause the loss of the tooth/teeth we are trying to treat with crown lengthening surgery.

Initials: _____

Sometimes complications may result from the crown lengthening surgery or from anesthetics or drugs. These complications include but are not limited, to post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter and transient (on rarest of occasions permanent) increase tooth looseness or tooth sensitivity to hot, cold, sweet ,or acidic foods and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. The exact duration of any complication cannot be determined and they may be irreversible. There is no method that will accurately predict or evaluate how the gum and bone will heal before the surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory.

Alternatives to suggested treatment: Alternatives to crown lengthening surgery include 1) no treatment. I understand that if no treatment is done by dentist may not be able to place a restoration or 2) extraction of the tooth or teeth involved;

Necessary follow-up care and self-care: I understand that it is important for me to continue to see my regular dentist for a routine Dental Care as well as to get the crown lengthened tooth/teeth restored with a filling or crown after the surgical area has healed (usually three months give or take) of that is needed.

I have told Dr._____ about any pertinent medical conditions I have, allergies especially two medications or sulfites many local anesthetics have sulfite preservatives or medications I am taking including over-the-counter medications such as aspirin. I will need to come for a post-op appointment following my surgery so that my healing may be monitored and so Dr._____ can evaluate in report on the outcome of surgery to my dentist. Smoking excessive alcohol intake or inadequate oral hygiene May adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to:

1. Abide by the specific prescriptions and instructions given
2. See Dr._____ for post-operative checkups as needed
3. Quit smoking
4. Perform excellent oral hygiene what's instructed to usually starting one week after the procedure is done
5. Have my dentist restore the tooth or teeth once the gums are healed

No warranty or guarantee: No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, it should be. Due to individual patient differences, however, there can never be a certainty of success. There is a risk of none success despite the best of care.

Initials_____

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 dentistry or in promotional materials. My identity will not be revealed to the General Public.

Communication with my insurance company, my dentist or other Dental or medical 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 healthcare provider I may have that may have need to know about my dental treatment.

Females Only: antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills) therefore I understand that I will need to use an additional form of birth control for one complete cycle other than birth control pills after a course of antibiotics is completed.

Consent

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling Dr. _____ of any pertinent medical conditions in prescription and non-prescription medications I am taking. I have had an opportunity to ask questions. I can sit to the performance of the oral surgery as presented to me during my consultation and as described in this document above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the doctor. I have read and understand this document before I signed it.

Date: _____

Patient Name: _____

Signature of Patient or Guardian: _____