CONSENT TO CROWN LENGTHENING

Patient: ______________________________

Tooth/Teeth # __________________________

1. **DIAGNOSIS**: After a careful oral examination and study of my dental condition, Dr. Everett has advised me that I have a need to lengthen one or more teeth due to caries, loss
of tooth structure, or an excessive gummy smile.

2. **RECOMMENDED TREATMENT**: In order to treat this condition, the doctor has recommended my treatment include gum surgery. I understand that sedation may be utilized and a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics may be used as part of my treatment.

Crown lengthening surgery will involve moving my gum tissue to a different position exposing more of my natural tooth. The gum will be reflected to see if there are any bone irregularities and these may be reshaped. Crown margins may become visible and you may choose to have the crowns replaced. For gummy smiles, the tissue will be reshaped to show more of your natural teeth. You may have crowns or veneers made to restore a more natural smile. Dissolvable sutures will be placed.

I further understand that unforeseen conditions may call for modification or change from the anticipated surgical plan. These may include, but are not limited to (1) extent of caries, (2) amount of remaining tooth structure, (3) level of existing bone.

3. **EXPECTED BENEFITS**: Healthier tissue, exposure of tooth structure to facilitate restorative treatment, aesthetics, and tooth stability.

4. **NECESSARY FOLLOW-UP CARE AND SELF CARE**: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of gum surgery. From time to time, the doctor may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the removal of existing restorations. I understand that failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I recognize that natural teeth and appliances 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 for the doctor to 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 outcome of my surgery. I know it is important (1) to abide by the specific prescriptions and instructions given by the doctor and (2) to see the doctor and my general dentist for periodic examinations and preventive treatment.
Maintenance also may include adjustment of prosthetic appliances.

5. **PRINCIPAL RISKS AND COMPLICATIONS**: I understand a small number of patients do not respond successfully to gum surgery. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the gum surgery including post-surgical infection, bleeding, swelling and pain; facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum; jaw joint injuries or associated muscle spasm, transient, on occasion permanent; increased tooth looseness; tooth sensitivity to hot, cold sweet or acidic foods; shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks; impact upon speech; allergic reactions and accidental swallowing of foreign matter. The exact duration of complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand there may be a need for a second procedure if the initial results are not
satisfactory. This may be due to unforeseen reasons, accidents or trauma to the area, or loss of blood supply. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to the doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical/anesthetic procedure. I understand that my diligence in providing the personal daily care recommended by the doctor and taking all prescribed medications are important to the ultimate success of the procedure.

6. **ANESTHESIA**: I understand that, if I desire or if Dr. Everett advises, sedative drugs may be used to reduce my anxiety and discomfort by making me relaxed and sleepy. Be advised that this type of sedation, conscious sedation, <u>**is not**</u> general anesthesia. You will be sedated <u>**but conscious**</u> and may be aware of your surroundings. These drugs may also
reduce my ability to remember events occurring on the day of the operation. I understand
and agree that if sedative drugs are required before or during surgery, <u>**I will not drive**</u> myself home following surgery, but will arrange to be driven and accompanied home. I agree not to operate a motor vehicle or hazardous machinery for at least 24 hours following surgery. The side effect of any intravenous infusion may include nausea and vomiting and seen most frequently is phlebitis. This side effect occurs in 1 to 4 percent of patients. Phlebitis is a raised, tender, hard inflammatory response, which can have onset from 24 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm, moist heat, yet tenderness and a hard lump may be present for up to a year. Intravenous anesthesia is a serious medical procedure and although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

7. **ALTERNATIVES TO SUGGESTED TREATMENT**: I understand that alternatives to surgery include (1) no treatment- with the expectation of possible advancement of my condition, which may result in premature loss of teeth and/or an impairment of my general health.

8. **NO WARRANTY OF GUARANTEE**: I hereby acknowledge no guarantee, warranty or assurance has been given to me that the proposed treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, the doctor cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best care.

9. **PUBLICATION OF RECORDS**: I authorize photos, slides, x-rays or any other viewings of

9. **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 and reimbursement purposes. My identity will not be revealed to the general public without my permission.

PATIENT CONSENT

I have been fully informed of the nature of surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity
of follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with the doctor. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in
this document. I also consent to the performance of such additional of alternative procedures as may be deemed necessary in the best judgment of the doctor.

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

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Signature – Patient,
Parent/Guardian Date