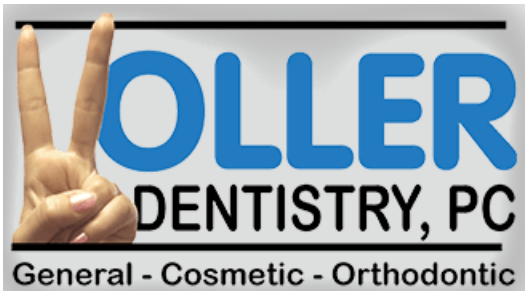

Adult Frenectomy Informed Consent Form

Diagnosis: After a thorough oral examination, my dentist has advised me that the revision of a frenum in my mouth may help to restore anatomy, function, and/or prevent commonly associated future problems.

Recommended Treatment: In order to treat this condition, my dentist has recommended that a frenectomy be performed at the selected site or sites. A soft tissue laser will be utilized. This laser is FDA approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery.

Principle Complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, discomfort, damage to adjacent structures such as salivary glands, nerve, muscle, or skin. A more common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up: I am advised to return for a 1-week check, and a 3 week check to follow up on the proposed care. There may be a referral to a myofunctional therapist or another professional for follow up care. Photos may be taken, but not of the face without permission.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve but may aggravate the surrounding tissues including the gums and teeth. Also, an alterative to a frenectomy by my dentist is to seek the care of another health care professional, including but not limited to doctors of periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

No Warranty or Guarantee:
I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I do expect however that the doctor perform the surgery to the best of her ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT
AND ALL MY QUESTIONS WERE ANSWERED

Date _____ _____
(signature of patient)