INFORMED CONSENT FOR CROWN LENGTHENING

Diagnosis: You have been diagnosed with inadequate tooth length. Your dentist has determined that a crown lengthening procedure should be performed prior to crown placement to insure a proper fit or for esthetics. This procedure is required due to the following: tooth fracture below the gum line, excessive decay, root decay or excessive gum tissue.

Recommended Treatment: Crown lengthening is a periodontal surgical procedure performed on teeth prior to crown or veneer placement or for esthetics. Local anesthetic will be used in the area of the procedure. Your dentist will create space around the tooth/teeth by removing small amounts of gum tissue, bone or a combination of both. Sutures will be placed in the area and a periodontal dressing may be used.

Upper Right □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ Upper Left

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Lower Right □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ Lower Left

Expected Benefits: The purpose of this procedure is to create space around the gum line of the tooth/teeth to allow the placement of a crown(s) or bridge with an adequate fit, to provide adequate "biologic width" and/or to improve esthetics of a "gummy" smile. There will be approximately 6-8 weeks of healing time after this procedure before your restorative work begins.

As in any oral surgery procedure, there are some risks of post-operative complications. They include, but are not limited to the following:

1. Swelling, bruising or discomfort in the surgery area.
2. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours or days.
3. Post-operative infection or graft rejection requiring additional treatment or medication.
4. Tooth sensitivity, tooth mobility (looseness) or teeth pain.
5. Gum recession/shrinkage creating open spaces between the teeth and making teeth appear longer.
6. Unaesthetic exposure of crown (cap) margins.
7. Food lodging between the teeth after meals, requiring cleaning devices such as floss for removal.
8. Numbness or altered sensations in the teeth, gums, lip, tongue and chin, around the surgical area following the procedure. Almost always the sensation returns to normal, but in rare cases, the loss may be permanent.
9. Limited jaw opening due to inflammation or swelling. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.

10. Stretching of the corners of the mouth resulting in cracking or bruising.
11. Damage to adjacent teeth, especially those with large fillings, crowns or bridges.

Alternative Treatment Options:
1. No treatment
2. Tooth Extraction (removal)

I have read and understand the above and give my consent for periodontal surgery. I understand that during the course of the procedure, unforeseen conditions may arise which necessitate procedure(s) that my dentist may consider necessary. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).

I hereby certify that I clearly understand and comprehend the nature, purpose, benefits, risks and alternatives to (including no treatment), the proposed procedure(s). I have been given the opportunity to ask questions and they have been answered to my complete satisfaction.

I further agree not to drive a car while under the influence of any sedative medication that the doctor has prescribed and to have a responsible adult accompany me until I am recovered from these medications. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, or past adverse reactions. I confirm that I have read and understand the above consent form and that I speak, read and write English.

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.

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.

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Patient's Signature Date Patient's Name

_____ _____ _____

Signature of Patient Guardian Date Relationship to Patient

_____ _____

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Signature of Dentist Date Witness