

PATIENT'S CONSENT FOR CROWN LENGTHENING SURGERY

Name _____ Date ____/____/____ Tooth _____

Upper Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Upper Left
Lower Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower Left

EXPLANATION OF DIAGNOSIS: I have been informed that there is not enough tooth structure to adequately support a restoration.

SUGGESTED TREATMENT: It has been suggested that my treatment include periodontal flap surgery and crown lengthening.

PURPOSE OF CROWN LENGTHENING: I have been informed that the purpose of this procedure is to obtain adequate, sound tooth structure. This procedure involves surgical flap reflection of the gingival tissues with bone re-contouring. When there are adjacent teeth, surgical crown lengthening involves a minimum of three teeth to avoid unhealthy, inconsistent gingival tissue and bony contours.

ALTERNATIVE TO THE SUGGESTED TREATMENT: The alternative may include: No treatment, and the expectation that my condition will advance, resulting in the possible premature loss of teeth; extraction of teeth involved.

PRINCIPLE RISKS AND COMPLICATIONS: Risks related to crown lengthening may include but are not limited to: post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient or possibly permanent numbness of the lip, tongue, teeth, chin, or gum; jaw joint injury or associated muscle spasms, transient or possibly permanently increased tooth looseness, or tooth sensitivity to hot, cold, sweet or acidic foods. Risks related to anesthetic might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness, or discoloration at the site of the anesthetic injection.

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, infections, or further bone loss or gum recession. It is anticipated that surgery will provide benefit in reducing the cause of this condition and produce healing that 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, even with the best of care, there exists the risk of failure, relapse, selective re-treatment, or worsening of my present condition, including the possible loss of certain teeth due to advanced involvement.

CONSENT TO UNFORSEEN CONDITIONS: Unforeseen conditions may be discovered during surgery that may 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 adjacent teeth, the removal of a hopeless root of a multi-rooted tooth to preserve the tooth, or termination of the procedure prior to completion of the surgical plan 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.

Initials: _____

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that **smoking and/or alcohol intake may affect gum healing and may adversely affect the successful outcome of my surgery.** I agree to follow instructions related to my own daily care of my mouth and to the use of prescribed medications. I agree to report for appointments following my surgery as suggested so my healing may be monitored, and the doctor may evaluate and report the outcome of surgery upon 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) on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of all, procedures related to crown lengthening as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Signature _____	Date ____/____/____
Patient / Responsible party	
_____	Relationship _____
Print name	to patient
_____	Date ____/____/____
Signature of witness	