



## **Informed Consent for Surgical Crown Lengthening/Gingivectomy**

**Diagnosis:** After a careful oral examination and study of my dental condition, the periodontist has advised me that I have insufficient crown length(s).

**Recommended Treatment:** To treat this condition the periodontist recommends that my treatment include surgical crown lengthening. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that a laser may be utilized. During this procedure, my gum may be opened to permit better access to the bone. Gum and bone irregularities may be reshaped, my gum may be sutured into position, and a periodontal bandage or dressing may be placed.

**Expected Benefits:** Surgical crown lengthening may be done to: even the gum line, remove excess gum and bone tissue, and/or expose more tooth structure so that restorations can be done. The surgery is intended to make a restorative or cosmetic procedure/result possible.

**Risks Related to the Procedure and Unforeseen Conditions:** I understand that a small number of patients do not respond successfully to surgical crown lengthening and, in such cases, the procedure may need to be re-done. Surgical crown lengthening may not be successful in preserving function or appearance. Potential complications include, but are not limited to, post-surgical infections, 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 but 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 on speech, allergic reactions, and accidental swallowing of foreign matter. I understand that there may be a need for a second procedure if the initial results are not satisfactory. Unforeseen Conditions 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 so as to preserve the tooth, 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.

**Alternatives to Suggested Treatment:** I understand that alternatives to Surgical Crown Lengthening include: (1) No Treatment: Expectation of probable advancement of condition,



which may result in an inability to place adequate restorations or achieve a satisfactory aesthetic result.

**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 failure to follow daily care instructions or report for follow-up appointments as needed may lead to further risks or complications.

**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the Surgical Crown Lengthening procedure will be successful. There is a risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth.

**Supplemental Records and Their Use:** I consent to the use of photography, video recording, and/or X-rays of my oral structures for both the above procedure(s) and educational use in lectures or publications, provided my identity is not revealed in compliance with HIPAA.

I, \_\_\_\_\_, understand the risks involved with Crown Lengthening and I release Dental TLC and any Dental TLC employees, agents or independent contractors from any liability related to Crown Lengthening.

\_\_\_\_\_

Signature

Date: \_\_\_\_\_