Perio & Implants

Consent for Crown Lengthening Surgery

During your initial consultation we discussed your need for crown lengthening surgery, steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure. **Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page**.

Suggested Treatment. It has been suggested that the tooth/teeth checked below are to be treated:

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

_____***1. Diagnosis.*** When a tooth is fractured or decay extends below the gum line, the bone and gum needs to be reduced in size around the teeth in order to get access to remove and restore the cavity, or to fix the tooth and place a filling or crown past the fracture. In order for the gum to heal against the tooth in a healthy manner, there must be sufficient space between healthy tooth structure and the crest of bone, which supports the tooth. This allows for proper attachment of the gum to the tooth.

_____***2. Recommended Treatment.*** After an examination and study of my dental condition, my periodontist has advised me that I would benefit from a crown lengthening surgery. Local anesthetics will be administered as part of the surgery. In order to provide your dentist with better access and tooth structure to fix your tooth the gum and the bone will be reshaped and repositioned. The gum will then be sutured back closer to the new bone level, and a periodontal dressing/packing may be placed. As expected, the surgery will make it look like the gum receded, making the teeth look longer. You may also notice open spaces between your teeth after the procedure.

_____***3. Expected Benefits.*** The purpose of the crown lengthening surgery is to give access for my dentist to correctly restore the tooth or teeth. The surgery is intended to help me keep my tooth/teeth in the operated area.

_____***4. Principal Risks and Complications.*** Some patients do not respond successfully to periodontal surgery. In addition, other things in the future, such as accidents, root canal problems, tooth decay, periodontal disease, etc. could also cause the loss of the tooth/teeth we are trying to treat with crown lengthening surgery. I understand that complications may result from the crown lengthening surgery and drugs or anesthetics administered. These complications include, but are not limited to:

A. Post---surgical infection, bleeding, swelling, pain, facial discoloration (bruising). Local anesthetic injection may cause allergic reaction, temporary or permanent injury to nerves and/or blood vessels.
B. During surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function. This can lead to transient (usually this disappears slowly over several weeks or months) but on occasion permanent numbness, itching, burning, pain or tingling of the

jaw, teeth, gums, tongue (including the possibility of loss of taste sensation), lip, chin, cheek, or in areas of the skin of the face.

C. Fracture of the jaws, fracture of the tooth/teeth during surgery. Loss or injury to adjacent teeth and soft tissue, loss or loosening of dental restorations, swallowing of a tooth or fragments of a tooth, accidental swallowing/aspiration of teeth, restorations and instruments.

D. Jaw joint injuries, pain or muscle spasm/stiffness cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, and transient (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods or shrinkage of the gum upon healing. The exact duration of any complication cannot be determined, and they may be irreversible.

_____***5. Alternatives to Suggested Treatment.*** Alternatives to crown lengthening surgery include:

A. No treatment (I understand that if no treatment is done, my dentist may not be able to place a restoration and my current condition may get worse).

B. Extraction of the tooth or teeth involved and exploration of other possible restorative options (implants, bridges or denture).

_____***6. Necessary Follow--up Care and Self--Care.*** I understand I will need to come for post---operative appointments following my surgery so that healing may be monitored, and my periodontist can evaluate and report on the outcome of surgery to my dentist. My diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed are important to the ultimate success of the procedure. Smoking, excessive alcohol intake or not following post---operative instructions may adversely affect gum healing and may limit the successful outcome of my surgery. I understand that it is my responsibility to return to my dentist for any restorations that are needed, after the surgical site has healed (usually about 6 weeks). Furthermore, it is important for me to continue to see my regular dentist for routine dental care.

_____ 7. ***Unforeseen Conditions.*** During the 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:

A. Extraction of the tooth or teeth that are to be crown---lengthened if they are found to be non---restorable (if a crown or filling cannot be done due to a very deep cavity or fracture), or to maintain healthy periodontal environment for the adjacent teeth.

B. Termination of the procedure prior to completion of the surgery as originally outlined.

C. Root amputation/resection of a multi---rooted tooth to preserve the tooth.

D. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best professional judgment of my periodontist.

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_____***8. No Warranty or Guarantee.*** No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences there can never be a certainty of success, despite the best of care. I understand, there is no method that will accurately predict or evaluate how the tissue will heal before the surgical procedure. There may be a need for a second surgery if the initial results are not satisfactory.

_____**9.** ***Use of Records for Reimbursement and Publication Purposes.*** I authorize photos, video recordings, x---rays, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will never be revealed to the general public.

_____***10. Females only.*** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the crown lengthening surgery, the alternative treatments available, and the necessity for follow---up care 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 my periodontist. After thorough deliberation, I hereby consent to the crown lengthening surgery as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document

Patient's Signature	Patient's Name
Signature of Doctor	Date
Signature of Witness	Date