Lakeshore **W**est **D**ental
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CONSENT FOR CROWN LENGTHENING SURGERY

PATIENT NAME:___________________________

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

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

Expected Benefits: The goal of Crown Lengthening is to create a positive and healthy periodontal architecture. Crown Lengthening will improve esthetics for individuals that have a "gummy smile" The space that will be created around the gum line of the tooth will allow adequate fit for the placement of a veneer, crown or bridge. A period of 6-8 weeks will be required for healing, and before you're restorative work begins.

Principal Risks and Complications: Surgical complications are very rare. All dental treatments have an associated risk. Periodontal surgery of any type may result in:

1. Bleeding. Significant bleeding is not common, but persistent oozing can be expected for several hours or days.
2. Swelling, bruising or discomfort.
3. Tooth sensitivity, tooth mobility or teeth pain.
4. Gum recession/shrinkage creating open spaces between the teeth and making teeth appear longer and unaesthetic exposure of crown margins.
5. Post-operative infection.
6. Numbness or altered sensations in the teeth, gums, lip, tongue and chin, around the surgical area following the procedure. Usually the altered sensation returns to normal, however in very rare cases, the loss may be permanent.
7. Damage to adjacent teeth, especially those with large fillings, crown or bridges.
8. Stretching of the corners of the mouth resulting in bruising or cracking.
9. Due to possible inflammation or swelling there may be limited jaw opening.
10. Food lodging between the teeth, will require cleaning with floss or soft-picks for removal.
11. Smoking may adversely affect gum healing and may limit the successful out come of the procedure.

Alternative Treatment Options:
1. No treatment
2. Tooth Extraction

***Patient initial*____**

Necessary Follow-Up Care and Self Care: I fully understand it is important for me to see my dentist for routine dental care.

I acknowledge smoking may adversely affect gum healing and may limit the successful outcome of my surgery.

I know I should use soft bristly toothbrushes or soft electric toothbrushes (such as Sonicare®) Good oral hygiene for the rest of my life is essential to good dental health.

I have told the dentist about any pertinent medical conditions, allergies (especially to medications or sulfites) or medication(s) I am taking, including over the counter medications such as aspirin.

I acknowledge I will need to come back for several post-operative visits so my healing may be monitored and to allow the Dentist to evaluate the healing process. Smoking, excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See the Dentist for post-operative visits as needed.
3. Quit smoking.
4. Perform excellent oral hygiene once instructed to, usually starting 4 weeks after the surgery is done.
5. Have the area reshaped, if needed, several months later, there is no extra charge for this.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Communication with my Insurance Company, My Dentist or other Dental/Medical Providers involved with my care: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, dentist's billing agency, my dentist, and any other health care provider I may have, who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Adverse Reactions to Medications: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of the same.

***Patient Initial*______**

I have been informed of the nature of my dental problem and 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 the 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 comprehend, understand the nature, purpose, benefits, risks and alternatives to the proposed treatment. I have had the opportunity to ask questions and they have been answered to my complete satisfaction.

I have given the Dentist a complete and truthful medical history, including all medications, non-prescriptions, drug use, pregnancy, or past adverse reactions.

I understand that Dr. Sam Patel is a general dentist and referral to a specialist has been offered and declined by me.

I confirm that I have read and understand the above consent before I signed it.

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Signature of patient, parent or guardian

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Print Name

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Signature of Dentist

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Date