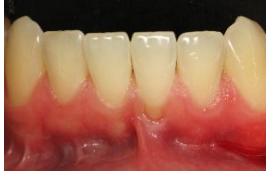
INFORMED CONSENT – FRENECTOMY (FRENULECTOMY)

Patient name: ____ **Date of birth:** __________________

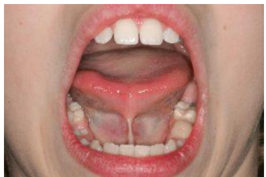
DIAGNOSIS & BENEFITS OF TREATMENT: The **frenum** is a ligament normally found in three places in the oral cavity. I have been informed of the presence of an **abnormal frenum attachment**. When the frenum is attached too tightly or is incorrectly positioned, treatment may be required to prevent or correct functional and esthetic issues. Following a comprehensive oral examination, and based upon my clinical symptoms, conditions and/or concerns, my doctor has identified the need for treatment of the following area(s):

☐ **Maxillary labial frenum attachment** *(upper arch)*



☐ **Mandibular labial frenum attachment** *(lower arch)*

When a **labial frenum** is attached too close to the teeth, it can be associated with *nursing problems in infants.* In older children & adults it is related to *more difficult plaque removal, gap (diastema) formation between the front teeth, greater plaque retention, gum recession & inflammation, a high risk of mouth breathing which can affect jaw growth & airway development.*



☐ **Mandibular lingual frenum attachment** *(lower arch)*

When a **lingual frenum** is attached too tightly to the tongue (***ankyloglossia*** – *"tongue tie"*), it is often associated with *abnormal growth of the lower jaw, sleep apnea, swallowing dysfunction, tongue thrusting, open bite & speech problems such as lisping, inability to roll 'r's', etc.*

A **frenotomy** is routinely performed at the hospital on newborns to help with feeding issues - the frenum is cut to allow for greater movement of the lips or tongue. A **frenectomy** *(sometimes referred to as a* **frenulectomy)** involves more complete removal of the ligament in a child or adult, often to help resolve issues related to *gum inflammation & recession* or the development of *gaps between the front teeth.*

ALTERNATIVE TREATMENTS. There are several methods by which the ***frenectomy*** may be accomplished. They include *laser therapy, scalpel therapy* or the use of *surgical scissors*. Advantages *(benefits)* of treatment involving **laser** vs. **scalpel** or **scissors** include lower probability of reattachment of the tissue, less bleeding, no sutures *(stitches).*

My doctor has recommended that I be treated with a ***frenectomy*** under **local anesthesia** using the following technique:

____

PURPOSE OF TREATMENT. My doctor has recommended a **frenectomy** procedure to treat the following condition(s):

❑ankyloglossia; ❑gingival recession & inflammation; ❑diastema; ❑other: ______________________________

RISKS OF NON-TREATMENT. Without treatment I understand that chronic gum inflammation may occur resulting in *increased tooth sensitivity (due to advancement of recession), increased risk of root surface decay*, *need for restorative treatment* to address sensitivity & caries, *need for more frequent professional care, worsening of my periodontal condition* & *tooth loss.* Without treatment, I understand that *diastemas are less likely to resolve & more likely to recur,* even with orthodontic intervention.

RISKS OF TREATMENT. While the majority of patients have an uneventful surgery & recovery, I understand that complications may occur. Risks/complications include, but are not limited to: *bleeding, bruising, swelling, pain, injury to other tissues, infection, burns (laser treatment), scarring which limits treatment success, reattachment of the frenum requiring a 2nd surgery.* Not all surgeries are successful in promoting diastema (*gap between teeth)* closure or halting the progression of gingival recession. I understand that even if this surgery is successful in stopping *progression* of diastemas and/or gingival recession, additional surgeries and/or orthodontic treatment may be necessary to correct existing issues which do not resolve as a result of this procedure. Risks related to anesthetics include but are not limited to *allergic reactions (potentially life threatening), accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthesia.*

CONSENT TO UNFORESEEN CONDITIONS. During surgery, I understand that unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. I consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

POST-OPERATIVE CARE. I agree to follow my doctor's written and verbal post-operative instructions regarding *wound management, dietary restrictions, oral hygiene procedures*, & *return visits.*

NO WARRANTY OR GUARANTEE. No guarantee, warranty or assurance has been given to me in regard to the outcome of the proposed surgical procedure. Despite the very best of care, individual differences make it impossible to ensure that every surgery is successful.

NITROUS OXIDE/ORAL SEDATION/IV SEDATION/GENERAL ANESTHESIA. I understand that if I choose to have surgical treatment performed under any type of sedation, in addition to **local anesthetic administration**, that I will be given the opportunity to discuss the risks & benefits of these options with my doctor, including the additional fees involved & special post-operative considerations before signing a **separate informed consent.**

MEDICAL HISTORY. I have provided as accurate and complete a medical and personal history as possible, including *antibiotics, drugs, or other medications I am currently taking,* as well as *those to which I am allergic.* I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

INFORMED CONSENT. I can read and write English and have been given the opportunity to discuss my treatment with my doctor and ask any questions regarding the nature, purpose, risks, benefits and fees of the proposed treatment and alternative treatments, including non-treatment. I have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, which may be associated with any phase of this treatment in hopes of obtaining the desired result. The fees for these services have been explained to me and I accept them as satisfactory. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

By signing this form, I am freely giving my consent to proceed with recommended treatment. I hereby authorize the doctors and staff at this office to render any services they deem necessary or advisable to treat my dental conditions.

Signed: ____ Date: _____________
Patient or Legal Guardian

Signed: ____ Date: ____________
Treating Dentist

Signed: ____ Date: ____________
Witness