CROWN LENGTHNING CONSENT FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*DIAGNOSIS*

After careful oral examination and evaluation, it has been determined a surgical procedure known as crown lengthening is required to properly restore the tooth. I understand there has been loss of part or the entire crown of the tooth due to fracture, or as a result of caries. The remaining tooth structure would make it extremely difficult to restore the tooth. This may result in eventual loss of the tooth. I understand if the surgical procedure is not performed, it may be impossible to restore the tooth in a satisfactory manner.

*RECOMMENDED TREATMENT*

In order to treat this condition, a surgical procedure has been recommended to expose more of the tooth. The gum tissue is opened or reflected away from the tooth, and some supporting bone is removed. This will provide adequate tooth structure to allow placement of a restoration. The gum tissue is placed at a more apical level on the tooth and secured with sutures. A periodontal dressing or bandage may be placed and retained for up to one week after surgery. Local anesthetic, pain medication and occasionally antibiotics are required.

*EXPECTED RESULTS*

The purpose of this procedure is to increase the amount of tooth structure required for the successful restoration on the tooth. This will enhance the periodontal and restorative prognosis of the tooth.

*POTENTIAL RISKS AND COMPLICATIONS*

I understand some patients do not respond successfully to a periodontal surgery. The gum tissue may heal in such a manner as to require a second procedure at the time of restoration. This usually entails removal of some gum tissue due to an overgrowth during healing.

I understand there may be complications arising from a surgical procedure. There may be some swelling of the area, facial bruising, transient or permanent numbness of the jaw, chin or tongue. There may be transient or permanent episodes of thermal sensitivity to sweets, heat and/or cold. Recession of the gum tissue is common as a result of the surgery. This may result in elongated teeth, with larger space between the teeth. This may result in esthetic concerns in those areas of the mouth which are visible.

I also understand at times there may be such extensive loss of tooth structure, a procedure termed “exploratory” will be recommended, and if it is determined the tooth cannot be saved, extraction may be necessary. Teeth with prior endodontic therapy may have small fracture lines due to their brittleness, and may facture at a later time. Other complications may include:

1) Post Surgical Infection

2) Bleeding, swelling, pain and discoloration of the facial areas

3) Transient and occasional permanent numbness of the lip, chin or jaw

4) Transient, and in some cases, permanent sensitivity of the tooth to heat, cold and sweets

5) Allergic reactions

6) Accidental swallowing of foreign matter.

The exact duration of complications cannot be determined, and may not be reversible. To my knowledge, I have reported all medical and allergic conditions that I am aware of. I also understand the importance of my diligence in practicing eff3ective personal oral hygiene, as well as the importance of taking all prescribed medications post surgically.

*NECESSARY FOLLOW UP-CARE AND SELF-CARE*

I understand the importance of regular dental care during the healing period for this procedure. I recognize that my natural teeth and any prosthetic appliances must be maintained daily in a clean hygienic manner. I understand the importance of follow up appointments after the surgical procedure to allow evaluation of the healing process

*NO WARRANTY OR GUARANTEE:*

I hereby acknowledge that no warranty, guarantee or assurance has been given to me that the crown lengthening procedure will be successful. In most cases, the treatment should provide improvement of my condition and should create an environment, which will aid in keeping the tooth. I understand there re differences in individual patients healing responses after a surgical procedure; therefore certainty of success cannot be predicted

*PUBLICATION OF RECORDS*

I authorize the use of slides, x-rays or other matters related to my case, which have been taken before, during or after its completion, to be used for teaching purposes and/or publication. I understand my identity will not be revealed without my permission.

*PATIENT CONSENT*

I have been fully informed of the nature of the procedure, and its risks and benefits as well as alternative to treatment and the necessity for follow-up and self-care. I have had an opportunity to ask questions concerning this treatment and the procedure has been discussed. After thorough deliberation, I hereby consent to the performance of such additional or alternative procedures that may be deemed necessary.

I certify I have read and fully understood this document.

Signed ..................................

Date .....................................