Center for Oral and Facial Surgery
Associates in Oral & Maxillofacial Surgery, P.C.

CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY & ANESTHESIA
CONSENT FOR FRENECTOMY

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Patient Name:_____ Account #_____

I hereby authorize Dr._____and staff to perform the following procedure:_____and to administer the anesthesia I have chosen, which is:

☐ local anesthesia ☐ nitrous oxide/oxygen analgesia ☐ intravenous sedation ☐ general anesthesia

1. I have been informed of possible alternate methods of treatment (if any,) including:

   _____

   I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.
2. In order to treat this condition, the doctor has recommended my treatment include gum surgery in order to remove the frenum. I understand that sedation may be utilized and a local anesthetic will be administered to me as part of the treatment.
3. I recognize that natural teeth and appliances should be maintained daily in a clean hygienic manner. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know it is important (1) to abide by the specific prescriptions and instructions given by the doctor and (2) to see the doctor and my general dentist for periodic examination and preventive treatment.
4. Principal Risks and Complications: I understand a small number of patients do not respond successfully to frenectomy surgery. Because each patient's condition is unique, long term success may not occur.
5. I understand that complications may result from the gum surgery including post-surgical infection, bleeding, swelling and pain; facial discoloration, transient but on occasion permanent numbness in jaw, lip, tongue, teeth, chin or gum; jaw joint injuries associated muscle spasm, transient, 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 upon speech; allergic reactions and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.
6. There is no method that will accurately predict or evaluate how my frenectomy will heal. I understand there may be a need for a second procedure if the initial results are not fully satisfactory. This may be due to unforeseen reasons, accidents or trauma to the area, or loss of blood supply. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to the doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical/anesthetic procedure. I understand that my diligence in providing the personal daily care recommended by the doctor and taking all prescribed medications is important to the ultimate success of the procedure.

Initial: _____

7. **ANESTHETIC RISKS** include: allergic reactions (previously unknown) to any of the medication used. Discomfort, swelling or bruising at the site where the drugs are placed into a vein. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage, and even death.

8. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
   A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until your are sufficiently recovered to care for yourself. This may be up to 24 hours.
   B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
   C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING.**
   D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a **small sip of water**.

9. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgement.

PLEASE ASK YOUR DOCTOR IF YOU HAVE QUESTIONS CONCERNING THIS CONSENT FORM.

My signature below signifies that all my questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

_____

Patient's or Legal Guardian's Signature Date

_____

Witness' Signature Date

_____

Doctor's Signature Date

If surgery date is different than date above, I have had the opportunity to again review, discuss, and change this informed consent.

_____

Patient's or Legal Guardian's Signature Date