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IMPLANT DENTISTRY | SLEEP APNEA & TMD

Informed Consent Crown Lengthening

Diagnosis: fracture, insufficient crown height, portion of tooth margin under gum line in close proximity to underlying bone, excessive gum tissue and/or decay on the following tooth/teeth.
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Purpose of Crown Lengthening: I have been informed that the purpose of crown lengthening is to increase the amount of tooth exposed above the gums to allow for more predictable crowns/fillings and/or improve esthetics.

Alternative Treatment: The following alternatives to crown lengthening have been explained to me:

- No treatment.
- Extraction (removal) and replacement with a prosthetic tooth (bridge, implant, denture).

Surgical Procedures may involve some, or all, of the following:

- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics and sutures (stitches).

Risks and Complications of crown lengthening: I understand that the risks and complications include, but are not limited to:

- Allergic reactions to dental materials/medications,
- Bleeding, swelling, infection,
- Pain,
- Temporary or permanent tooth sensitivity,
- Bruising,
- Scarring,
- Cuts inside mouth or on lips,
- Slow healing,
- Temporary restriction of mouth opening,
- Increased tooth/teeth mobility,
- Stress or damage to jaw joints (TMJ)
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate, chin) including loss of taste which may resolve or time, but in some cases may be permanent,
- Impact on speech,
- Fracture of temporary crown (if applicable),
- Gum recession on the tooth in question and neighboring teeth,
- Unaesthetic exposure of crown margins,
- Inadequate esthetic outcome which may necessitate additional treatment,
- Food lodging between teeth after meals.

Risks and Complications of local anesthetic use: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, which may occur from the delivery of local anaesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

No Warranty or Guarantee: I understand that the doctor cannot guarantee the results of the procedure. I under-stand that there may be a need for a second procedure if the initial surgery is not satisfactory.

Timing of healing: For posterior teeth, I understand that there may be 6-8 weeks of healing before restorative work begins. For anterior teeth, I understand that there may be 3-6 months of healing before restorative work begins.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions:
In order to increase the chance of achieving optimal results, I have provided and accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand that trauma to the healing areas, smoking, medical conditions, clenching and/or grinding of teeth, dietary and nutritional problems, alcohol intake and medications I may be taking may affect healing and may limit the successful outcome of my surgery.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of my past post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to crown lengthening grafting as presented to me during the consultation and treatment plan presentation by the dentist.

_____ _____ _____
Signature of Responsible Party Date Patient's Name

_____
Relationship to Party (if Responsible Party is not Patient)

I confirm with my signature that I have discussed with the above-named patient the risks, potential complications, and intended benefits of the dental implants, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I complete the crown lengthening for him/her.

_____ _____
Signature of Dentist Date

_____ _____
Witness to Signatures Only Date