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Consent for Crown Lengthening Surgery

Diagnosis: When a tooth is fractured, or decay extends below the gum line, the bone and gum needs to be reduced in size around the teeth in order to obtain access to remove and restore the cavity, or to fix the tooth and place a filling or crown past the fracture. In order for the gum to heal against the tooth in a healthy manner there must be 3 millimeters of healthy tooth between the margin of the filling or crown and the crest of bone, which supports the tooth. This allows for proper attachment of the gum to the tooth.

In the case of a gummy smile, my gums need to be reduced in size so my teeth have a more normal appearance.

Recommended Treatment: After a careful oral examination, radiographic evaluation and study of my dental condition, the dentist has advised me that I would benefit from crown lengthening surgery. Local anesthetic (commonly called Novocain) will be administered as part of the surgery. During the procedure, my gums will be opened to permit better access to the roots and jaw bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. In order to gain greater tooth length, some bone will be removed around the tooth/teeth to be lengthened as well as the adjacent teeth, and any bone irregularities may be reshaped. My gums will then be sutured into position and a periodontal bandage or dressing may be placed.

Expected Benefits: The purpose of crown lengthening surgery is to provide more healthy tooth structure to work with when restoring/repairing my tooth/teeth, as well as to provide my dentist better access and visualization. It will also help create a biologic width which will reduce post-operative inflammation, and is intended to help me keep my tooth/teeth that are in this area.

Principal Risks and Complications: I understand that some people do not respond successfully to crown lengthening surgery. The surgery may not be successful in preserving function or appearance. Because each person's condition is unique, long-term success may not occur. In rare cases the involved teeth may still be lost. Temporary, but on occasion permanent, increased tooth looseness may occur. If during the surgery the dentist finds a very deep cavity, fracture, or any other finding that would compromise my tooth/teeth, the crown lengthening procedure may be stopped and the tooth would be extracted at or after the time of surgery

As with any surgical procedure, complications involving the gums, jawbone, drugs or anesthetics may result from this crown lengthening surgery. These complications include, but are not limited to, post-surgical infection, bleeding, swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, temporary (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods. The exact duration of any complication cannot be determined, and may be irreversible.

There is no method that will accurately predict or evaluate how the gum and bone will heal before the surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory.

Alternatives to Suggested Treatment: Alternatives to crown lengthening surgery include:

1. No treatment. I understand that if no treatment is done, my dentist may not be able to place a proper restoration and save the tooth.
2. Extraction of the tooth/teeth involved.

Necessary Follow-up Care and Self Care: I understand that it is important for me to continue to see my dentist for routine care, as well as to get the crown lengthened tooth/teeth restored with a filling or crown after the surgery has healed (usually 6 – 12 weeks) if that is needed.

I have told the dentist and/or dental staff about any medical conditions I have. This includes allergies (especially to medications or sulfites), and all prescription or over-the-counter medications I am taking (such as aspirin).

I will need to come for post-op appointments following my surgery so that healing may be monitored, and sutures or dressings removed. 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. Follow the specific instructions given;
2. Take medications exactly as prescribed;
3. See the dentist for post-operative appointments as advised;
4. Quit smoking;
5. Perform excellent oral hygiene as instructed, usually starting one week after the surgery is done;
6. Have my dentist restore the tooth/teeth without delay once the gums are healed.

No Warranty or Guarantee: No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, it should be. Due to individual differences, however, there can never be a certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including possible loss of teeth despite the best of care.

Communication with my Insurance Company, Dentists or Other Providers: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion, to my insurance carriers, the doctors billing agency, other dentists involved with my treatment, 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.

Procedure(s) to be performed:

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking.

I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist.

I have read and understand this document before I signed it.

Signature of patient, parent or guardian

Printed Name

Date

Signature of Dentist/Staff

Printed Name

Date