FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

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Consent For Frenectomy

Patient Name:_____ Date:_____

DIAGNOSIS: I have been informed of the presence of a frenum that might be exceptionally short, thick, tight, or may extend too far down along the gum. When a frenum is positioned in such a way as to interfere with normal alignment of teeth or to impinge on the gingiva (gums), it can be excised with a surgery called a Frenectomy.

PURPOSE OF FRENECTOMY SURGERY: A Frenectomy is a simple surgical procedure that removes or loosens a band of tissue that is connected to the lip, cheek or floor of the mouth. The surgery can cause very little bleeding, does require sutures and often results in some post-procedure discomfort. The procedure will be performed using a local anesthetic.

RISKS RELATED TO THE SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to frenectomy surgery might include post-surgical infection, bleeding, bruising, swelling, or pain. Risks related to the anesthetics might include but are not limited to; allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthesia.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in reducing the interference with the normal alignment of the teeth or impingement on the gingiva (gums). It may need to be retreated. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition.

PATIENT'S ENDORSEMENT: My signature on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of the Frenectomy surgery as presented to me during the consultation by the doctor and treatment plan presentation by the office manager or as described in this document

Patient (or Legal Guardian) Signature:_____ Date:_____

Dentist Signature:_____ Date:_____

Witness Signature:_____ Date:_____