Consent for Crown Lengthening Surgery

Patient Name: _____

This consent for treatment is given to the attending doctor after having first been fully informed of the diagnosis, the proposed treatment, treatment alternatives and risks.

DIAGNOSIS: Based on the information gained from an examination of the conditions for which I sought treatment, my diagnoses, which have been explained to me, are:

Tooth/Teeth #_____ Restoration of this tooth (teeth) is complicated because the margins of the planned restoration must be placed subgingivally in an inaccessible area, resulting in violation of the biologic width.

TREATMENT: I have been advised that the following treatment is indicated:

Tooth/Teeth #_____ Periodontal surgery with osseous recontouring is needed to lengthen the clinical crown(s) and expose restorative margins.

ALTERNATE TREATMENT: Alternative treatments include but are not limited to: continuation of current dental care and seeking other opinions regarding my condition.

NON-TREATMENT RISKS: The possible consequences of not treating these conditions include but are not limited to: tooth loss, chewing difficulty, further bone loss and possible infections and abscesses.

TREATMENT RISKS: There are certain risks and potential consequences of any type of dental treatment. For the treatment recommended above, these risks include but are not limited to: pain, hot and cold sensitivity, infections, abscesses, failure of bone formation to occur, bleeding, gum recession, inability to chew, speaking difficulties, tooth mobility, food impaction, staining of teeth, a change in the bite, temporomandibular joint (jaw) pain, damage to existing crowns or fillings, changes in the appearance of teeth and gums, and numbness of the face, lip or gums. I understand that by the very nature of treatment for diseases and the uniqueness of myself as an individual that no outcomes are certain, and that even with treatment my condition could continue or worsen. I also understand that for successful periodontal treatment results and to lessen the dangers of complication, the following conditions are required of me; effective oral hygiene, following all instructions given, the proper use of any appliance provided, cooperation in making and keeping appointments, adherence to the maintenance and follow-up program.

I have had an opportunity to ask questions about the proposed treatment, alternatives and risks. All questions that I have asked have been fully answered to my satisfaction. I have had the opportunity to discuss my medical history and general health with the doctor indicating any serious problems, injuries, or allergies.

I understand that no guarantee or assurance has been given to me that the proposed treatment would fully satisfy my expectation. I believe that it is in my own best interest to proceed with the proposed treatments.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT DESCRIBED ABOVE. I ACCEPT THE RISKS OF HARM IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULTS OF THIS TREATMENT.

Patient Signature _____ Date _____

Legal Guardian (if patient is under 18 years of age) _____

Signature of attending doctor _____

Signature of Witness _____

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