

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.

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 aesthetics.

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

- No treatment.
- Extraction (removal) of the tooth and replacement with a prosthetic tooth (bridge, implant or 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 over 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 aesthetic 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 understand 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 an 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 any 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 as presented to me during the consultation and treatment plan presentation by the dentist.

You or your responsible party will have the opportunity to sign an electronic copy of this form when you arrive at our office for your appointment.