Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

INFORMED CONSENT FOR LASER FRENECTOMY/OPERCULECTOMY

I, as authorized guardian of the child being seen today, have been informed of the laser frenectomy/operculectomy procedures to be administered to my son/daughter. The benefits and possible risks of treatment, as well as alternative care options were discussed and I was provided ample opportunity to have all of my questions and concerns addressed. The option of "no treatment" was also presented and it is understood that this option was not elected as the potential benefit for treatment vs. no treatment is understood.

The pediatric dentist and staff will be performing a laser frenectomy/operculectomy (involving laser and possibly scalpel or blade) to release the physical restriction of the frenulum (tissue in the oral cavity.) The intent is to remove the frenulum which through reported symptoms, physical exam, and written history provides reason for treatment. The expectation is that by removing the frenulum, there will be the establishment of a more normal lip and/or tongue posture and movement. It is understood that though the intent is to alleviate the problem by frenectomy/operculectomy, there is no inherent guarantee that this will result in a cure of the problem, or concerns discussed. However, it is understood that the frenulum is likely a contributing cause to the current symptoms. I further understand that I am responsible to provide the post-op stretching exercises as directed, as well as following up with an additional provider other than my pediatric dentist, such as *speech language pathologist/pediatrician/lactation consultant/myofunctional therapist* to ensure full stretching and follow-up is met. This will help ensure the best possible result.

Local Anesthetic (numbing medication)
The treating Doctor may use local anesthetic to help your child feel comfortable during the procedure.

Possible Risks or Complications
I understand that all dental and medical treatment pose foreseen and unforeseen risks. These risks include, but are not limited to, the following:
 Swelling, bleeding, bruising and/or pain after the procedure
 Decision to leave a small piece of root/tooth of the primary or permanent tooth in the jaw when its removal would require extensive surgery or increased risk to nearby teeth or permanent teeth developing under primary tooth
 Possible infection and/or hospitalization and/or referral to a specialist for further treatments
 Injury to nerves in or around the mouth that could cause partial, full temporary, or permanently numb lips, chin, tongue, or loss of taste sensation
 “Dry Socket” or slow healing of an extraction site
 Injury to nearby teeth or fillings

□ Sore jaw or restricted mouth opening or TMJ problems (jaw joint may not function well)
□ Unusual reaction to medications given or prescribed
□ Anesthetic Risk (numbing medication): include discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip/cheek chewing.

Post-op complications may be discomfort, irritability, fatigue, temporary refusal to eat, and possible swelling and fever. It is very unlikely that there will be any infection.

The nature and purpose of the treatment and procedures have been explained to me in general terms by Dr. Trupkin, Wilentz, and Chizner Steinberg. Alternative procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness of each, as well as a prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent form, I have been given an opportunity to ask questions I may have, and that all questions about the procedure (s), have been answered in a satisfactory manner; and I understand further that I have the right to be provided the answers to questions that may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and if so desire, need to notify the provider. This signed written consent will remain in effect until such time that I choose to terminate it by verbal and written notification.

_____ _____

Parent/Guardian's Signature Name of patient receiving treatment

_____ _____

Today's Date Witness's Signature