Periodontics & Dental Implants
Dr. Alexander Kim, D.D.S., INC.
10430 South De Anza Blvd., Suite 290
Cupertino, CA 95014

PATIENT'S CONSENT FOR FRENECTOMY

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 the 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 Frenectomy surgery might include post-surgical infection, bleeding, brushing, 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.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

NITROUS OXIDE (optional): Nitrous oxide/Oxygen inhalation is a mild form of conscious sedation used to calm an anxious patient. A colorless, odorless gas that has no explosive or flammable properties, it can act as a pain buffer as well. Oxygen is given simultaneously with the Nitrous Oxide through a small mask placed over the nose. Pure Oxygen, given at the end of treatment, is intended to flush the Nitrous out of the patient's system and minimize the effects of the gas. The patient remains awake and can respond to directions and questions. Nitrous Oxide helps overcome apprehension, anxiety, or fear. Nitrous risks include but are not limited to: Inability to perceive one's spatial orientation and temporary numbness and tingling. Nausea and vomiting may occur.

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, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to Frenectomy surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

- ☐ I have read and fully understood the terms within this document and consent to the procedure as described above.
- ☐ I have read and fully understood the terms within this document and refuse to give my consent for the proposed treatment plan as described above. I have also been informed of and accept the consequences if no treatment is administered.

Patient's Signature (or guardian if patient is a minor) Print Name Date

Signature of Witness Print Name Date