Summit View Periodontics
Consent for Aesthetic and/or Functional Crown Lengthening Surgery

Crown Lengthening is a procedure designed to expose more tooth structure to permit for a crown or filling, but it may also be performed to remove excess gum (e.g. correct a "gummy smile"). The procedure involves all the components of conventional gum surgery. Typically, a restoration may be placed approximately 8 to 12 weeks post-surgery, unless directed otherwise.

Procedure details: I understand that my crown lengthening surgery may involve making an incision in the gum and lifting the gum to expose the roots of my teeth and underlying bone. The excess gum is removed, the teeth and roots are cleaned, the bone may be adjusted, and sutures placed. This procedure is performed with local anesthesia and any desired medication for my comfort. For laser based surgeries, the gums are not lifted, nor sutured. Lasers gently remove the excess tissues which exposes the underlying tooth structure below. Some procedures require a blending of conventional surgery and laser therapy. My dentist will accurately determine which approach is right for me after my teeth and gums are anesthetized.

Expected Benefits: The purpose of periodontal surgery is to create a healthy and improved foundation for my restorative care. I anticipate an improvement in my appearance, but perfection is not achievable. The surgery may help make my oral hygiene more effective, but in some circumstance crown lengthening could make hygiene more challenging. The procedure may also enable my dental professionals clean my teeth more effectively.

Principal Risks and Possible Complication: I understand that a small number of patients do not respond successfully to periodontal surgery. Periodontal surgery may not always be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking, or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed is important to the ultimate success of the procedure.

Alternative Treatment: I understand that alternatives to crown lengthening surgery may include: 1) No treatment, with the expectation of possible advancement of my condition which may result in premature loss of teeth and poor esthetics. 2) Extraction of the involved teeth, with replacement by dental implants, bridge work, partial dentures, or complete dentures. 3) Extraction without tooth replacement.

Necessary Follow-Up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success of failure of periodontal therapy. From time to time, my periodontist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public without my permission.

Patient Consent: I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____	_____	_____
(Date)	(Signature of patient/parent/guardian)	(Printed name of patient/parent/guardian)
_____	_____	
(Date)	(Doctor's signature)	
_____	_____	_____
(Date)	(Signature of witness)	(Printed name of witness)