Tuan M. Nhu, DDS

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GERMANTOWN DENTAL VILLAGE

CONSENT FOR FRENECTOMY

I hereby authorize Dr. Tuan Nhu to perform a frenectomy. I also understand that Dr. Nhu is not a specialist (periodontist or oral surgeon), and I am declining immediate referral to a specialist at this time. I further understand that Dr. Nhu may cease treatment and make a referral to a specialist should any unanticipated difficulty or untoward event occur during or after treatment at my additional expense.

I understand that a frenectomy is a surgical procedure to **remove the band of tissue (frenum)** that stretches between the inside of the lip to the gum tissue, which may inhibit function or cause complications in development in some cases. I understand that a frenectomy has been recommended for the following reason or reasons:

- ☐ To minimize the potential for diastema, or midline "gap", development
- ☐ To facilitate proper function of a removable denture
- ☐ To improve the prognosis of gum surgery
- ☐ To minimize the potential for gum recession

I have been informed of the reasons for the surgery, and the details of the procedure have been explained to me; I fully understand them.

I understand that my gum tissue will be cut, and bone may be injured during the procedure. A full-thickness incision may be made, and sutures may or may not be placed, depending on the situation.

I understand that following the completion of the surgery there may be a period of discomfort accompanied by some bleeding, swelling, and pain.

I have been made aware that smoking will jeopardize the healing process after surgery.

If I am taking any anticoagulant medication such as warfarin (Coumadin), aspirin, or any blood-thinning supplements, I have informed Dr. Nhu and acknowledge that we have discussed the risks of prolonged bleeding times. I understand that if bleeding does not stop in a reasonable time period, that I will need to seek care at the nearest Emergency Room at my own expense.

I understand that following surgery, there may be a period of numbness of the jaw, some swelling, bleeding, discoloration, and possible discomfort. I understand that because the position of the nerves in the area of the surgery cannot be clearly determined by x-rays (radiographs), injury to the nerves may be unavoidable and may result in loss of sensation to the chin, lips, and tongue for a period of time. I have been told that although it is usual for the numbness to be temporary it may, on rare occasions, be permanent.

I understand additional complications, although rare, may occur, and I am to notify Dr. Nhu as soon as they are noticed so that appropriate follow-up care can be arranged. I also understand that revision procedures may be necessary in the future and that reattachment of the muscle fibers is possible.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I further understand that gum disease or loss of attachment is a chronic condition which may progress or worsen with or without surgery.

I have discussed all of the above with the doctor, and have had all my questions answered.

Patient Signature: _____ Date: _____

Dentist: _____ Date: _____

Witness: _____ Date: _____