INFORMED CONSENT FORM FOR CROWN LENGTHENING SURGERY

PATIENT'S NAME (PRINTED) _____
Area treated: _____

After careful examination and study of my dental condition, my dentist has advised me that I require a crown lengthening procedure which is a surgery whereby more tooth structure is exposed so that the dentist can secure crown on the tooth without impinging on the gingiva. In order to perform the crown lengthening procedure, my dentist has explained to me that there will be a local anesthetic that will be administered to me as part of the treatment. The risks from local anesthesia includes numbness, temporary or permanent, involving the lip, chin, cheeks, gums, teeth, and tongue as well as altered sensation, discoloration, bruising, swelling, dizziness, and vomiting.

My dentist has also explained to me that the crown lengthening procedure carries with it its own material risks which include post-surgical infection, bleeding, swelling, pain, facial discoloration, transient or permanent numbness to the teeth, gums, tongue, lips, chin, cheek and jaw, tooth sensitivity to hot, cold, sweet, or acidic foods, loss of tooth, the possibility of having to undergo a root canal or apicoectomy, loss of gum tissue, exposure of adjacent root structures and the root structure to the teeth or tooth being operated upon, exposure of fillings, restorations, and margins, trismus, jaw pain, joint pain, muscle pain, and aesthetic changes including a tooth which looks longer in nature, less gum tissue, etc. I also understand that should any of these risks in fact occur, then further procedures may be necessary to fix the problem. Further procedure called gingivectomy/gingivoplasty may be needed to smooth gingiva if indicated after the healing. I also understand that, once a crown is attached to the tooth, the margins may not be perfect, there may be an unfavorable crown to root ratio, and the crown may still fail.

I also understand that the success of any crown lengthening procedure can be effected by my underlying medical or dental condition, dietary and nutritional problems, smoking, alcohol, clenching or grinding of my teeth, inadequate oral hygiene, inadequate follow up with a dentist or dental hygienist, and the medications that I am taking. I understand that my diligence in performing personal daily care recommended by my dentist and hygienist and taking prescribed medications are important to the ultimate health of my gums, teeth, and crowns.

My dentist has explained to me the potential alternative treatments to the crown lengthening procedure. These include, among other things, doing nothing, having regular dental cleanings to try to stabilize my gum condition, and the extraction of the tooth involved. The risks of these alternative procedures include infection, tooth loss, tooth fracture, further damage to gums and surrounding tissues, failure of fillings, failure of crown and bridgework, inadequate margins, decay, and failed treatment. I reject these alternative treatments and choose crown lengthening procedure to be done. I hereby acknowledge that doctor has not promised, warranted, or guaranteed the success of the surgical procedure. I authorize doctor to perform the crown lengthening procedure.

Patient signature: _____

Witness signature: _____

Dentist signature: _____

Date: _____