

## Consent for Crown Lengthening Surgery

I hereby authorize Dr. Wiesenmayer to perform a crown lengthening procedure on tooth (teeth) # \_\_\_\_\_, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Alternative Treatments include \_\_\_\_\_.

### Reason for Crown Lengthening

When a tooth is fractured or decay extends below the gum line, the bone and gum needs to be reduced in size around the tooth in order to get access to remove and restore the cavity, or to fix the tooth and place a filling or crown past the fracture. In order for the gum to heal against the tooth in a healthy manner there must be 3 millimeters of healthy tooth between the margin of a filling or crown and the crest of bone, which supports the tooth. This allows for proper attachment of the gum to the tooth. In the case of a gummy smile, my gums need to be reduced in size so my teeth have a more normal appearance.

### Recommended Treatment:

The gum will be trimmed and pulled away from the teeth to permit better access to the roots and jawbone. The gum tissue and bone will be reshaped. The gum will then be sutured back closer to the new bone level, and a periodontal dressing (like a plaster pack) might be placed. The gum may be at a slightly lower level following surgery, allowing better access for my dentist to restore the tooth.

### Potential Risks and Complications:

1. Post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm.
2. Cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks.
3. Impact on speech, allergic reactions, accidental swallowing of foreign matter
4. Transient (on rarest of occasions permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods.
5. Transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. The exact duration of any complication cannot be determined, and they may be irreversible.

6. Unforeseen conditions may call for a modification or change from the anticipated surgery plan. These may include, but are not limited to, 1) extraction of the tooth or teeth that are to be crown lengthened if they are found to be non-restorable 2) termination of the procedure prior to completion of the surgery as originally outlined.
7. Other occurrences in the future, such as accidents, root canal problems, tooth decay, periodontal disease, etc. could also cause the loss of the tooth/teeth we are trying to treat with crown lengthening surgery.

Certain medical problems, medications, and using tobacco products may alter the success of this surgery. I understand that in order to increase the success of the surgery, proper home hygiene and follow up care will be needed.

I consent to the administration of **local anesthesia, nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above (circle all that apply). Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination.

I certify that I have read the above and fully understand this consent for treatment. I understand that a perfect result cannot be guaranteed. I am aware of the fee(s) associated with this treatment and am responsible for any and all payments not covered by my insurance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

I have been advised that crown lengthening surgery is beneficial for the restoration of my tooth. I understand that without this surgery, the best outcome cannot be achieved. Permanent gum inflammation, damage to the underlying bone, and decreased retention of restorative material are the potential outcomes of not receiving treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_