Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Crown Lengthening Consent:

Patient Name: _____ Date: _____

Tooth #(s): _____

Diagnosis: When a tooth is fractured or decay extends below the gum line, the bone and gum needs to be reduced in size around the teeth in order to obtain 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 the 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: After a careful oral examination, radiographic evaluation and study of my dental condition, the dentist has advised me that I would benefit from crown lengthening surgery. Local anesthetic will be administered as part of the surgery.

During the procedure, my gums will be opened to permit better access to the roots and jaw bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned.

In order to gain greater tooth length, some bone will be removed around the tooth or teeth to be lengthened as well as the adjacent teeth and any bone irregularities may be reshaped. My gum will then be sutured into position and a periodontal bandage (*perio-pack, plaster dressing)* or dressing may be placed.

Expected Benefits: The purpose of crown lengthening surgery is to provide my general dentist or Prosthodontist better access and visualization, as well as providing more tooth structure to work with when restoring/repairing my tooth/teeth. It will also help create a biologic width which will reduce post-operative inflammation and is intended to help me keep my tooth/teeth in the operated area.

Principal Risks and Complications: I understand that some patients do not respond successfully to crown lengthening surgery. The surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases the involved teeth may ultimately be lost. Transient, but on occasion permanent, increased tooth looseness may occur. If during the surgery the dentist finds a very deep cavity, fracture or any other finding that would compromise my tooth (teeth), the crown lengthening procedure will be stopped and the tooth would be extracted at or after the time of surgery

Complications may result from the crown lengthening surgery involving the gums, jawbone, drugs or anesthetics. These complications include, but are not limited to post surgical infection, bleeding, swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint pain or muscle spasm, 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, accidental swallowing of foreign matter, transient (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods. The exact duration of any complication cannot be determined, and may be irreversible. There is no method that will accurately predict or evaluate how the gum and bone will heal before the surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory.

Alternatives to Suggested Treatment: Alternatives to crown lengthening surgery include:

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1. No treatment. I understand that if no treatment is done, my dentist may not be able to place a proper restoration

2. Extraction of the tooth/teeth involved

Necessary Follow-up Care and Self Care: I understand that it is important for me to continue to see my regular dentist for routine care, as well as to get the crown lengthened tooth/teeth restored with a filling or crown after the surgery has healed (usually 3 months, give or take) if that is needed.

I have told the dentist and/or his/her staff about any pertinent medical conditions I have, allergies (*especially to medications or sulfites*) or medications I am taking, including over the counter medications such as aspirin.

I will need to come for post-op appointments following my surgery so that healing may be monitored and so the dentist can evaluate and report on the outcome of surgery to my general dentist. Smoking, excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to:

1. Abide by the specific prescriptions and instructions given.

2. See the dentist for post operative check-ups as needed.

3. Quit smoking.

4. Perform excellent oral hygiene once instructed to, usually 1 week after the surgery is done.

5. Have my general dentist restore the tooth/teeth once the gums are healed.

No Warranty or Guarantee: No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, it should be. Due to individual patient differences, however, there can never be a certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including possible loss of teeth despite the best of care.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (*birth control pills*). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist. I have read and understand this document before I signed it.

X_____ Date: _____

Patient/Guardian Signature

Employee/Assistant Initials: _____