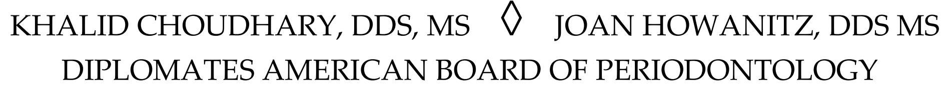
NORTH BETHESDA PERIODONTAL GROUP



KHALID CHOUDHARY, DDS, MS ◊ JOAN HOWANITZ, DDS MS

DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

Consent for Crown Lengthening Surgery

Patient Name: ____ Date: ____________________

1. **Recommended Treatment and Expected Results:** After an examination and study of my dental condition, Dr. Choudhary/Dr. Howanitz has recommended that I have crown lengthening surgery. It has been explained to me that the surgery involves trimming and pulling the gum away from the teeth, reshaping the gum and bone, and suturing the gum closer to the new bone level. I understand that the surgery may make the gums look receded my teeth will look longer, and may create spaces between the teeth.

2. **Anesthesia and medications:** I consent to the administration of local anesthesia. I understand that the risk of using anesthesia includes: discomfort, bleeding, swelling, bruising, infection, prolonged numbness or dizziness, nausea and allergic reactions. I have disclosed all pertinent medical conditions that I may have, allergies especially to medications or sulfites, as many local anesthetics contain sulfite preservatives) or medications that I am taking, including over-the-counter medications such as aspirin.

3. **Principal Risks and Complications:** Complications to the gums or jawbone include, but are not limited to, post-surgical infection, bleeding, swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint 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, and transient (or even permanent on occasion) increased tooth looseness, sensitivity to hot/cold/sweet/acidic foods. The exact duration of any complication cannot be determined beforehand, and they may be irreversible. I understand that unforeseen conditions may be a need for additional surgery if the initial results are not satisfactory. I understand that unforeseen conditions may call for a modification or change from the anticipated surgery plan. Modicfication may include, but are not limited to,
   - **a.** Extraction of the tooth or teeth that are to be crown-lengthened if they are found to be non-restorable.
   - **b.** Termination of the procedure prior to completion of the surgery as originally outlined.
   - **c.** Such additional procedures as are necessary in the exercise of professional judgment.

4. **Necessary Follow-Up and Self Care:** After surgery, I understand that I must do the following, or else risk limiting/preventing a successful outcome of my surgery:
   - **a.** Abide by the specific prescriptions and instructions given.
   - **b.** See Dr. Choudhary/Dr. Howanitz for post-operative follow-up appointments.
   - **c.** Quit smoking and avoid excessive use of alcohol.
   - **d.** Perform excellent oral hygiene as instructed (usually 1-week after surgery).
   - **e.** Continue my dental care with my general dentists.

5. **No Warranty or Guarantee:** No guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, there can never be a certainty of success or exact result.

6. **Female Patients Using Oral Birth Control Pills:** I understand that antibiotics may interfere with the effectiveness or oral contraceptives and that I must therefore use additional birth control pills for one complete cycle after a course of antibiotics is completed.

CONSENT: I understand that no guarantee as to results (functional, aesthetic, or otherwise) can be or has been promised. I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature: ____ Date: ______________________

Dentist Signature: ____ Date: ______________________

Witness Signature: ____ Date: ______________________