Consent for Crown Lengthening

BABAK NOOHI, DDS, MS **CAPITOL HILL DENTISTRY**

I hereby authorize Doctor BABAK NOOHI, and whomever he may designate as his assistant, to perform the following treatment and/or surgery upon: _____.
(Name of patient)

DIAGNOSIS

I have been informed that I have Periodontal (gum) Disease and/ or deformities that could lead to loss of certain of my teeth. Specifically, I need crown lengthening procedure in order to provide adequate tooth structure for restorative work and also to provide biologic width for the health of my gums. I have been advised that the proposed therapy is intended to extend the life expectancy of my teeth. This consent form outlines that treatment, its expected consequences, and limitations.

Surgical site(s): #

TREATMENT PROCEDURES

- ☐ Oral Hygiene
- ☐ Chemical pocket irrigation and antibiotic therapy
- ☐ Polishing and scaling root planing and/or curettage (tooth and/or gum scraping)
- ☐ Periodontal Surgery (gingivoplasty; flap surgery with osseous contouring).
- ☐ Extraction of teeth or roots as determine during surgery
- ☐ Root desensitization therapy (If needed in the future)
- ☐ Periodontal maintenance therapy (professional recall care)
- ☐ Nitrous oxide (laughing gas)
- ☐ Temporary Splinting (as indicated)

ALTERNATIVES

Further, I have been informed that possible, alternatives to the above treatment include:

- Maintenance therapy only.
- Other: Doing Nothing.

NON-TREATMENT RISKS

I further understand that if no treatment is rendered the risks to my dental health include, but are not limited to, the following:

- Premature loss of teeth
- Persistent inflammation
- Gum recession
- Halitosis (bad breath)
- Abscesses (gum boils)
- Deepening of periodontal pocket(s) and/ or pus pockets
- Deteriorating functional abilities

TREATMENT RISKS

Risks of the treatment include, but are not limited to:

- Swelling
- Pain
- Infection
- Phonetic interferences (difficulty with speech)
- Food impaction and spaces between teeth
- Temporary restricted mouth opening
- Numbness of jaw or gum (mainly associated with the lower jaw surgeries)
- Exposure of margins of crowns (caps) and / or root surfaces
- Other i.e.,
- Tooth mobility
- Tooth sensitivity to hot and/ or cold
- Root resorption

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CONSENT TO UNFORSEEN CONDITIONS DURING SURGERY

If any other unforeseen condition should arise in the course of treatment calling for the Doctor's judgment for procedures, in addition to or different from those now contemplated, I further authorize the Doctor to do whatever he may deem advisable.

PHOTOGRAPHS

In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures, and subsequent publication solely for the educational and scientific purposes. These photographs will be exposed in such a way as to protect my anonymity.

NO WARRANTY

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/ or successful. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth.

It has been explained to me that the long term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office.

I certify that I have read fully, understood and have had all of my questions answered so that I understand the above consent to treatment.

DATE: _____/_____/20____ **SIGNED :**_____

Patient or Legal Guardian (Print your name and sign)

WITNESS (Dental Assistant)**:**_____

DOCTOR: BABAK NOOHI, DDS, MS

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