deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR CROWN LENGTHENING

PATIENT NAME_____DATE_____TOOTH #_____

Upper Right ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Upper Left
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 19
Lower Right ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Lower Left

EXPLANATION OF DIAGNOSIS: I have been informed that there is not enough tooth structure to adequately support a restoration.

SUGGESTED TREATMENT: It has been suggested that my treatment include periodontal flap surgery and crown lengthening.

PURPOSE OF CROWN LENGTHENING: I have been informed that the purpose of this procedure is to obtain adequate, sound tooth structure. This procedure involves surgical flap reflection of the gingival tissues with bone re-contouring. When there are adjacent teeth surgical crown lengthening involves a minimal of three teeth to avoid unhealthy, inconsistent gingival tissue and bony contours.

ALTERNATIVE TO THE SUGGESTED TREATMENT: These may include:
1) No treatment with the expectation of the advancement of my condition resulting in the possible premature loss of teeth:
2) extraction of teeth involved.

RISKS RELATED TO THE SUGGESTED TREATEMENT: Risks related to crown lengthening might include but are not limited to the post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient or on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweets or acidic food. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetic.

Initial here _____

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NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in crown lengthening the involved tooth. It is anticipated (hoped) that surgery will provide benefit, which will enhance the possibility of longer retention of my teeth; but, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective treatment, or worsening of my present condition including the possible loss of certain teeth with the advanced involvement despite the best care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the use of material to guide (enhance) tissue regeneration or termination of the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THERE USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all, procedures related to crown lengthening as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Signature of Patient, Parent or Guardian	Date
Printed Name of Patient	Relationship to patient
Signature of Witness	Date

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