Issaqueena Pediatric Dentistry
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Child's name: _____ DOB: _____

After a thorough oral examination, the reduction of a frenum(s) attachment in my child's mouth has been recommended and may help to restore anatomy, function, and/or possibly prevent commonly associated future problems.

Recommended treatment: In order to treat this condition, the dentist has recommended that a frenectomy be performed at the selected site(s):

□ **Maxillary labial frenum (beneath upper lip)**

□ **Lingual fredum (beneath tongue)**

□ **Other frenum site:** _____

A soft tissue laser will be utilized and is FDA approved for soft tissue surgery. Soft tissue lasers tend to lessen discomfort during treatment and recovery.

Patient safety: I understand that protective stabilization may be used to gently ensure my child's safety during the frenectomy procedure (applies to infants and small pre-cooperative children only). Nitrous oxide and mouth props (to assist with keeping mouth open) will likely be utilized for older children. Oral sedation with midazolam may also be utilized at the discretion of the dentist. Protective eyewear must be worn by all people present in the treatment room, including my child. I understand all of the previous are for my child's safety.

Did your child receive Vitamin K injections? Yes ☐ **No** ☐

Principle complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a small number of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, pain, damage to adjacent structures such as salivary glands, nerves, muscle, and skin. Such complications may require care from an additional healthcare provider such as an oral surgeon. A common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar or overt fibrous tissue formation.

Post- op care and follow up: I understand that I must follow the daily therapy exercises instructions to lessen the risk of frenum reattachment. I am advised to return for a follow-up appointment to evaluate healing at the discretion of the dentist.

Photos: Pre-op and post-op photos may be taken for documentation and insurance purposes, but not of child's face without permission.

Alternatives to suggested treatment: I understand that alternatives to a frenectomy include: no treatment, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth. Also, an alternative to a frenectomy by my dentist is to seek the care of another healthcare professional, including but not limited to doctors of general dentistry, periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

No warranty or guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful.

I certify that I have read and fully understand this document and all my questions were answered.

_____	_____	_____
Print name (parent/guardian)	**Sign name (parent/guardian)**	**Date**
_____	_____	_____
Print name (dentist)	Sign name (dentist)	Date