LOVE YOUR SMILE
FAMILY & AESTHETIC DENTISTRY

Patient Initial

DISCUSSION & CONSENT FOR CROWN LENGTHENING

Patient's Name: _____ Date of Birth: _____

Nature of Treatment

It has been recommended that I have the following tooth (teeth) crown lengthened:

_____

In order to treat my condition, my dentist has recommended that a crown lengthening procedure be performed to expose some of the tooth structure under the gum level. I understand that local anesthetics will be administered to me as part of the treatment. This minor surgical procedure involves trimming some of the tissues around the teeth in the area to allow proper restoration of the teeth involved. Sometimes, the bone around the teeth are re-shaped to improve contour and healing.

This recommendation is based on visual examination(s), on any diagnostic imaging, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration.

This procedure is necessary because of: ☐ gummy smile (altered passive eruption or altered active eruption)
☐ restoration impingement of biological width due to decay or teeth fracture ☐ compensatory eruption
☐other:_____

The intended benefit of crown lengthening is improved esthetics (may or may not be combined with restorative work) and/or improved form and function of teeth.

The prognosis, or likelihood of success, of this procedure is _____.

My crown lengthening is estimated to cost $_____ and is estimated to take _____ visit (s) to complete.

Alternatives

Depending on my diagnosis, there may or may not be an alternative to crown lengthening that involves other types of dental care. Tooth #_____can be restored/retained by:

☐ Extraction ☐ No treatment ☐ Other: (compromised restoration, etc) _____

Risks of Procedure

Risks related to crown lengthening include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but 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 or cold or sweets or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Risks related to anesthetics might include but are not limited to allergic reactions, accidental

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swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

Discussion & Consent for Crown Lengthening (page 2)

Acknowledgement

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including diagnostic imaging.

I realize that in spite of the possible complications and risks, my recommended extraction/surgery/treatment is necessary. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure. I have received information about the proposed treatment. I have discussed my treatment with Dr. Beverly Jaiswal and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment and the risk of refusing treatment.

I understand that the treatment can also be performed by an oral surgeon or periodontist (specialists). I understand the risks and elect to have the procedure performed by Dr. Beverly Jaiswal. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

_____	_____	_____
Patient or Guardian Signature	***Date***	***Time***
_____	_____	_____
Treating Dentist Signature	***Date***	***Time***
_____	_____	_____
Witness Signature	***Date***	***Time***