



Robert L. Delarosa, DDS · Bradley S. Comeaux, DDS · Paige Sigsworth, DDS · Brynn L. Leroux, DDS · Stephanie Sotile, DDS  
· Courtney Brashier, DDS · Elizabeth Auld, DDS- General Dentist

## FRENECTOMY INFORMED CONSENT

### RISKS OF PROCEDURE

While the majority of patients have an uneventful procedure and recovery, a few cases may be associated with complications. There are some risks/complications, which can include:

Bleeding either at the time of the procedure or in the first 2 weeks after.

Infection

Pain

Scarring

Allergic reactions

Injury to the base of the tongue or the sublingual salivary gland, which sits below the tongue. This may require further surgery.

Dehydration. It is extremely important to keep your child hydrated postoperatively.

Injury to the teeth, lips, gums, tongue, cheeks, and/or eyes.

Burns from the equipment on skin or mucosa

Frenum reattachment requiring further surgery

Bruising, swelling and inflammation, especially of upper lip

Transient numbness in lips, teeth, or tongue

Fire due to laser use in proximity to combustible gases

### PARENTAL CONSENT

I acknowledge that my child will undergo the procedure while the parents remain in the waiting area, if applicable. I am aware that it is not uncommon for my child to be fussy for up to a week after the procedure. It is also not uncommon to see bloody spit up after the procedure as well as stools that are unusual in appearance or darker in color due to swallowed blood. I acknowledge that the doctor has explained my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. By signing this consent, I indicate that I have the legal authority to grant this permission. I also agree to pay all fees and have given Associates in Pediatric Dentistry a complete medical history of my child.

**On the basis of the above statements, I REQUEST THAT MY CHILD HAS THIS PROCEDURE.**

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Substitute decision maker: \_\_\_\_\_

Witness: \_\_\_\_\_ Doctor: \_\_\_\_\_