ASSOCIATES IN PEDIATRIC DENTISTRY
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 by 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 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: _____**

During office procedures, photographs or videos of interesting cases may be completed. We would like to have your consent to use these for research and educational purposes, such as lectures or professional articles, to advance breastfeeding and improvements in speech and feeding difficulties. Your child will not be identified in any photo. I understand that photographs or video footage may be taken during my child's procedure, and these may be used for teaching health professionals.

**Signature of Parent/Substitute decision maker: _____**

I have been instructed and have had the opportunity to ask questions and gain additional information regarding my child's aftercare. I understand that I am accountable and responsible for the stretches/exercises given and recommendations regarding follow up care provided by the doctors of Associates in Pediatric Dentistry and any lactation consultants or therapists that have provided advice or services involved in the treatment of my child.

**Name of Patient: _____ Date: _____**

**Signature of Parent/Substitute decision maker:_____**

**Witness: _____ Doctor: _____**

**A one week and four week post-op appointment will be scheduled for my child the day of the procedure. Both are included with the frenectomy fee. There will be a $85 fee for any additional post- ops that may be needed. Stretching only visits are also available for $50 per visit. If I am unable to make any of these appointments, I will call to reschedule. Initial: _____**

***AS ALWAYS, PLEASE CONTACT OUR OFFICE WITH ANY UNRESOLVED PROBLEMS OR CONCERNS.***