DAVID B. KRILL, D.M.D., INC.

PERIODONTICS AND ORAL DIAGNOSIS
8221 CORNELL ROAD
CINCINNATI, OH 45249
(513) 891-3933
FAX (513) 891-5979

An explanation of your need for crown lengthening surgery, the procedure and post -operative care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo this procedure. Please read this document which repeats issues we discussed and provides the appropriate signatures on the last page. Please ask us to clarify anything that you do not understand.

PATIENT'S CONSENT FOR CROWN LENGTHENING SURGERY

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of insufficient tooth structure and/ or decay below the gum line in my mouth. I understand that it is important to have a sufficient tooth structure for the placement of fillings or crowns.

PURPOSE OF CROWN LENGTHENING: I have been informed that the purpose of a crown lengthening is to create an adequate amount of tooth structure for fillings or crowns.

SUGGESTED TREATMENT: It has been suggested that a crown lengthening be performed in areas of my mouth where I have insufficient tooth structure. It has been explained that this is a surgical procedure involving the removal of gum and possibility bone from the associated tooth or teeth.

RISKS RELATED TO THE PROCEDURE: Risks related to crown lengthening might include but are not limited to post-operative bleeding, numbness, swelling, pain, infection, facial discoloration, transient or on occasion permanent tooth sensitivity to hot or cold or sweets or acidic foods. 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 anesthetics.

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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 exposing additional tooth structure. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective, re-treatment, or worsening of my present condition care.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/ or alcohol intake may affect 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 & THEIR USE: I consent to photographs, 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 SIGNATURE: My endorsement (signature) to this form indicates that I have read and fully understand the terms and works 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, I give my consent for the performance of any and all procedures related to crown lengthening surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

____________________	______________	________________________ of
Patient's signature	Date	Relationship to Patient
		________________________
		Patient's Name
____________________	______________	
Signature of Witness	Date	
____________________	______________	
Signature of Doctor	Date	