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

PERIODONTICS AND ORAL DIAGNOSIS
8221 CORNELL ROAD
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(513) 891-3933
FAX (513) 891-5979

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

PATIENT'S CONSENT FOR FRENECTOMY SURGERY

DIAGNOSIS: I have been informed of the presence of a high frenum at the gum line in my mouth. I understand that it is important ro have this frenum eliminated or repositioned to prevent recession of the gum tissue on the adjacent teeth and to prevent spacing of the teeth.

PURPOSE OF FRENECTOMY: I have been informed that the purpose of a frenectomy is to eliminate tension (pull) on the adjacent gum tissue.

SUGGESTED TREATMENT: It has been suggested that a frenectomy be performed in areas of my mouth where I have heavy or excess tension. It has been explained that this is a surgical procedure involving the removal and a repositioning of the frenum.

RISK RELATED TO THE SUGGESTED TREATMENT: Risks related to frenectomy might include but are not limited to post-operative, bleeding, 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.

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 eliminating tension on the gum tissue. 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, but due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition care.

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COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect 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 photography, filming, recording and radiographs 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 words 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 related to periodontal flap surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

_____ _____ _____
Patient's Signature (Signature of Parent or Legal Guardian if the patient is a minor) Date Relationship to patient

_____
Patient's Name

_____ _____
Signature of Witness Date

_____ _____
Signature of Doctor Date