PROSTHODONTIC ASSOCIATES

INFORMED CONSENT FOR CROWN LENGTHENING SURGERY

This letter is meant to review the recommended crown lengthening surgical procedure. Please review this letter. Should you have any further questions before starting treatment, please do not hesitate to have these clarified with myself.

Crown lengthening is a procedure intended to increase the amount of tooth exposed above the gums. Dentists often need more tooth exposed above the gumline in order to prepare the tooth for a veneer of a crown (or cap as some call it). Following freezing by local anesthesia, an incision is made around the tooth and the gum tissue is gently reflected. Then a small of amount of the bone around the tooth is removed. Finally, the gum flaps are sutured together in their new position, to expose more tooth structure above the gumline. A periodontal bandage or dressing may be placed over the surgically-treated area. The purpose of the crown lengthening procedure is to provide the general dentist more access as well as more tooth structure to work with when the tooth is restored thereby increasing the retention of the restoration to be placed. It will also help create a biologic width which will reduce post-operative inflammation.

Following any intra-oral surgical procedure, a patient can typically expect some pain, discomfort, mild swelling, bruising or discoloration. You will receive post-operative instructions on how to minimize these effects, following the surgical procedure. Other risks associated with the proposed procedure involve infection of the surgical site, damage to adjacent teeth, and disturbance of the sensory nerve which provides that area of the lower jaw with sensation to the skin of the chin, cheeks, and lips. Please note that ***these complications are possible, not probable, and with proper planning they are largely avoidable.***

The estimated fee for crown lengthening surgery has already been provided to you. Payment is due in full on the day of the procedure.

Please sign below if you have read and understood the proposed surgical treatment as it indicates your acceptance of the terms and information provided.

Patient Signature _____ Date _____

Signature of Dental Specialist _____

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