Child Frenectomy
Informed Consent Form

Diagnosis: After a thorough oral examination, my child's dentist or pediatrician has advised me that the reduction of a frenum(s) in my child's mouth may help to restore anatomy, function, and/or possibly prevent commonly associated future problems.

Recommended Treatment: In order to treat this condition, my child's dentist or pediatrician has recommended that a frenectomy be performed at the selected site(s). A soft tissue laser will be utilized. This laser is FDA approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery.

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:

- **Reattachment of the frenum requiring additional surgical procedures** ***this is the most common complication**
- Bleeding either at the time of the procedure or in the first 2 weeks after
- Infection
- Pain
- Fussiness
- Damage to, or infection of the sublingual gland, which sits below the tongue which may require further surgery
- Impact on speech
- Lack of improvement
- Injury to the teeth, lip, gums, or tongue
- Alterations in child's smile, including increased show of upper gums when smiling (for lip tie release)
- Burns from the equipment
- Swelling and inflammation, especially of upper lip
- Scarring
- Eye damage if baby looks directly into the laser beam (eye protection is always used)
- Inability to complete procedure (children who are too strong/resistant may need to be referred for sedation)

Follow Up: I am advised to return for a 1 week check, and a 3 week check to follow up on the proposed care.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth. Also, an alternative to a frenectomy by my dentist is to seek the care of another health care professional, including but not limited to doctors of general dentistry, periodontics, oral surgery, ENT, and plastic surgery. The procedure can be performed with a scalpel or scissors instead of a laser.

PARENT CONSENT I acknowledge that the doctor has explained my child's condition and the proposed procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I understand that a small number of patients do not respond successfully to this procedure. Because each patient's condition is unique, long-term success may not occur and is not guaranteed. I understand that failure to follow recommendations could lead to ill effects, which would become my sole responsibility. I will need to come for appointments following my surgery so that my healing may be monitored.

I was able to ask questions and raise concerns with the doctor about 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 photographs or video

footage may be taken during my child's procedure and these may be used for teaching health professionals. (Your child will not be identified in any photo or video).

I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements, I (name of parent/legal guardian)_____ request that

my child (name) _____undergo the procedure(s) described above.

Signature of Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Doctor: _____ Date: _____
Meggan M.H. Wehmeyer, DDS, MS