



Krizman Dental
INTEGRATIVE BIOLOGICAL DENTISTRY

Jeanne Anne Krizman, DMD
1601 N. Tucson Blvd., Suite #35
Tucson, AZ 85716
520-326-0082

CONSENT FORM FOR FRENECTOMY & UPPER LIP TIE RELEASE

Diagnosis:

My baby has been carefully examined and I have been advised that he / she has excessive gum tissue between the lip and jaw bone (labial frenum) and / or a tight band between the tongue and the floor of the mouth (lingual frenum). I understand these tight attachments can limit function during breastfeeding, speech, swallowing, TMJ function and sleep apnea.

Recommended Treatment:

I understand the doctor has recommended a procedure to either release the tight frenum (frenotomy) or removal of the tight frenum (frenectomy). I understand that topical anesthetic and/ or local anesthetic may be administered as part of the treatment.

ALTERNATIVE TREATMENTS

The alternative to laser treatment includes scalpel surgery using local anesthesia and/or sedation. The other alternative is to do no treatment. No treatment could result in some or all of the conditions listed under "Symptoms" above. Advantages (benefits) of laser vs. scalpel or scissors include lower probability of re-healing, less bleeding, no sutures (stitches) or having to remove sutures. Disadvantages (risks) are included in the "Risks of Procedure" below.

RISKS OF PROCEDURE

While the majority of patients have an uneventful surgery/procedure and recovery, a few cases may be associated with complications. There are some risks/complications, which can include:

Bleeding. This may occur either at the time of the procedure or in the first 2 weeks after.

Infection.

Pain.

Damage to sublingual gland, which sits below the tongue. This may require further surgery.

Injury to the teeth, lip, gums, or tongue.

Burns from the equipment.

The frenum can heal back and require further surgery.

Swelling and inflammation, especially of upper lip.

Scarring is rare but possible.

Eye damage if baby looks directly into the laser beam. Complete eye protection is mandatory and will be worn by baby and staff.

NECESSARY FOLLOW-UP CARE

I understand that failure to follow Dr. Krizman's recommendations could lead to undesired outcomes, which are my sole responsibility. I will need to come to follow up appointments after the procedure so that healing may be monitored and for the doctor or lactation consultant to evaluate and assess the outcome upon healing completion.

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 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 and that the procedure may make my child's condition worse. I understand that my child may need another procedure if the initial results are not satisfactory. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE.

Name of Patient: _____ Date: _____

Signature of Parent/Substitute decision maker: _____

Witness: _____ Doctor: _____