Krizman Dental
INTEGRATIVE BIOLOGICAL DENTISTRY

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CONSENT FORM FOR FRENECTOMY & UPPER LIP TIE RELEASE

Diagnosis:
My baby has been carefully examined and I have been advised that he / she has excessivegum tissue between the lip and jaw bone (labial frenum) and / or a tight band between thetongue and the floor of the mouth (lingual frenum). I understand these tight attachmentscan limit function during breastfeeding, speech, swallowing, TMJ function and sleepapnea.

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 orall 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 ofProcedure” 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, whichcan 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 orlactation 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 proceedure. I understand the risks of the procedure, including the risks that are specific tomy child and the likely outcomes. I was able to ask questions and raise concerns with thedoctor about my child's condition, the procedure and its risks, and treatment options. Myquestions and concerns have been discussed and answered to my satisfaction. I
understand that photographs or video footage may be taken during my child's procedureand these may be used for teaching health professionals. (Your child will

not beidentified in any photo or video). I understand that no guarantee has been made that theprocedure 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 MYCHILD HAS THE PROCEDURE.

Name of Patient: _____ Date: _____

Signature of Parent/Substitute decision maker: _____

Witness: _____ Doctor: _____