DENVER PERIODONTICS & IMPLANT DENTISTRY

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CONSENT FOR FIBEROTOMY

DIAGNOSIS: I understand that after evaluation of my current periodontal condition, Heather Richardson DMD MS has recommended a fiberotomy, known as a supra-crestal fiberotomy. I understand that the procedure will involve the use of a blade and or instrument, to make an incision through the gum tissue around one or several teeth in an attempt to sever the gum tissue fibers that attach to the tooth. I understand the goal of this procedure is to prevent orthodontic relapse, or rotation and/or movement back to the original tooth position prior to orthodontic treatment. I understand that this procedure will require the use of local anesthetic.

RISKS: A fiberotomy procedure is a surgical procedure and as such involves risk of complications. The risks involved may be, but are not limited to: bleeding, swelling, bruising, pain, infection, sore jaws, loose / discolored fillings and crowns, recession, tooth sensitivity to hot and cold, caries exposure, mobility, numbness, need for tooth extraction, and or tooth fracture.

I understand that every person responds to treatment differently. Therefore, it is impossible for the doctor to predict how long the healing period may require or if time away from normal routines may be necessary.

I understand that smoking may significantly interfere with healing and may inhibit healing and negatively affect the results of the procedure.

I understand every reasonable effort will be made to ensure that my condition is treated properly; however, it is not possible to guarantee perfect results or reoccurrence of tooth movement.

I understand if no treatment is rendered or if active orthodontic treatment (including use of a retainer as recommended by the orthodontist) is interrupted or discontinued, my periodontal condition would likely continue and worsen. This may result in further rotation and/or movement of the tooth.

ALTERNATIVES TO TREATMENT: I have been advised of my alternatives to this treatment and understand what has been proposed thoroughly.
Alternatives may include:

1. No treatment

USE OF LASER: I have been informed that the procedure can be performed with a traditional periodontal instrument and/or blade or with a dental laser. I understand that both procedures have been shown to be effective in removing unwanted tissue and in reshaping and/or recontouring the tissue. I understand that use of the laser will be up to the discretion of my doctor based upon the appearance and thickness of the tissue, and the amount of tissue that needs to be removed.

CONSENT: By signing this form I am consenting to the procedure as recommended by my doctor at DPID . I also agree that all of my questions have been answered to my satisfaction.

_____ _____

Patient's (or Legal Guardian's) Signature Date

_____ _____

Witness' Signature Date