Adult Frenectomy Informed Consent Form

Diagnosis: After oral examination, my dentist has advised me that the revision of a frenum in my mouth may help to restore function, and/or prevent commonly associated future problems.

Recommended Treatment: In order to treat this condition, my dentist recommended a frenectomy be performed at the selected site or sites. 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.

Principle Complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, discomfort, damage to adjacent structures such as salivary glands, nerve, muscle, or skin. A more common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up: I am advised to return for a 1-week check, and a 3 week check to follow up on the proposed care. There may be a referral to a myofunctional therapist or another professional for follow up care. Photos may be taken, but not of the face without permission.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve 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 periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

No Warranty or Guarantee:
I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I do expect however that the doctor perform the surgery to the best of their ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED.

_____ _____

Date Patient Name – Printed

_____

Patient Signature

Privacy Act, Financial Agreement and Photo Release

Patient Name (please print) _____

Notice of Uses and Disclosures of Protected Health Information

I acknowledge I have been provided with the Notice of Privacy Practices by Judith M. Strutz, DDS. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations, as well as my individual rights and the duties of Judith M. Strutz, DDS with respect to my protected health information.

I understand that Judith M. Strutz, DDS may *use* or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained, or received by Judith M. Strutz, DDS that identifies me, or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for dental/medical services.

Judith M. Strutz, DDS reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. Judith M. Strutz, DDS will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting Judith M. Strutz, DDS and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: _____ ***Date:*** _____

I understand that Judith M. Strutz, DDS will, as a courtesy, provide me with the information needed to receive reimbursement from my dental or medical insurance plan. I agree to be financially responsible for services rendered at the time of service.

Patient Signature: _____ ***Date:*** _____

The Undersigned hereby grants permission to Judith M. Strutz, DDS of San Bernardino, CA to use photos for the purpose of education and/or marketing in magazines, brochures, business cards, websites and newsletters.

Patient Signature: _____ ***Date:*** _____