Infant / Child Frenectomy Consent

The purpose of this procedure at a young age is to allow the baby to latch properly during breastfeeding and reduce maternal discomfort. For older children the purpose is to gain and maintain good oral health, allow for more normal growth, allow for correct speech development, and to reduce any future problems associated with lingual and or lip-ties.

Principle Complications: 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.

During treatment, it may be necessary for your child to be restrained and for the office staff to control undesirable movements. Dr. Strutz may use a small amount of topical anesthetic and local anesthetic to numb the area so your child will be comfortable during the procedure. The procedure is generally quick and there is very minimal bleeding. The laser cauterizes as it trims away the oral tissues causing little bleeding and resulting in an almost scar free wound that will heal in one to two weeks.

Dr. Strutz anticipates great results; however, there are no guarantees as to how much benefit will be achieved after the procedure. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post surgical discomfort may be minimal or last as long as a week. Most parents say that their child was fussy the first night but had no complications. You may choose to give your child children's pain medication, but it is usually not necessary for most patients. After completing this type of surgery, this office has not experienced any significant problems that would indicate any serious risks of the surgery.

Not treating your child's existing dental problem may result in continued breastfeeding problems, complications with bone growth and tooth eruption, and complications with future orthodontic treatment. Parents and guardians should understand recommended procedures, alternative options and anticipated results.

All surgery in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this surgery depend on parents following all post-operative recommendations for keeping the surgical sites from healing together.

ACKNOWLEDGMENT OF INFORMED CONSENT

I herby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have been given the opportunity to ask Dr. Strutz all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary, informed consent for treatment to be completed. By signing this consent, I indicate that I have the legal authority to grant this permission. I certify that I read and write English and have read and fully understand this consent. I also agree to pay all fees and have given Dr. Strutz a complete medical history of my child.

_____ _____

Date Signature of Parent/Guardian

_____ _____

Print Name Relationship to Patient

Privacy Act, Financial Agreement and Photo Release – Infant / Child

Patient Name (please print) _____

Date of Birth _____

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.

Parent / Guardian 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.

Parent / Guardian 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.

Parent / Guardian Signature:_____Date: _____