

# Judith M Strutz DDS, MEd

## Frenotomy Consent

**Diagnosis:** I have provided the dentist a complete medical history of myself (or my child). After a careful oral examination of my (or my child's mouth), the dentist has advised me that the examination demonstrates abnormal tension/shortened bands under the tongue, central lip or other areas in the mouth and that these bands may be related to symptoms being experienced. Revision of a frenum may help to restore function, and/or prevent commonly associated future problems.

**Recommended Treatment:** In order to treat this condition, my dentist recommended a procedure to release the tight bands (Frenotomy) be performed at the selected site or sites. I understand that a topical numbing gel will be utilized and injected local anesthetic will be administered as part of the treatment. A soft tissue laser will be utilized. This laser is FDA approved for this soft tissue surgery. Vitamin K is a recommended treatment prior to undergoing any infant surgical procedure – the lack of Vitamin K is associated with increased rates of neonatal hemorrhage. I am advised to return for a 1-week check, and further checks as needed to follow up on the proposed care. Photos may be taken, but not of the face without permission.

**Principle Risks and Complications:** I understand a small number of patients experience problems after the procedure. Risks include:

- Pain
- Bleeding (especially if Vitamin K has not been administered)
- Infection
- Damage to salivary glands (resulting in blockage or ranula) and/or salivary ducts
- Damage to underlying muscles and/or nerves
- Aversion to any feeding
- Re-attachment of the bands causing return of symptoms
- Failure to improve
- Need for repeat surgery or any other surgeries (to treat complications or reattachments)

**Alternatives to Suggested Treatment:** I understand that alternatives to a frenotomy include: no frenotomy, 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 frenotomy 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.

**Necessary Follow Up and Self Care:** I understand that failure to follow recommendations could lead to ill effects, which is my sole responsibility. I know it is important to abide by the specific instructions given by the doctor. Continued involvement with the lactation consultant, speech pathologist, myofunctional therapist or other health care professional is mandatory and critical in improving symptoms.

**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 will perform the surgery to the best of their ability.

I have asked all of my questions and have had time to discuss options with the dentist. By signing I elect to proceed with the procedure for myself (or my child).

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name – Printed

\_\_\_\_\_  
Patient/Guardian Signature