Jessica Wagner Sabo DDS, Inc

Release of Information (optional)

Jessica Wagner Sabo DDS, Inc providers and/or their agent are authorized and are given consent to copyright or publish photographs of signed patient. These photographs are to be used for educational purposes only (ie. Frenectomy education, medical/dental journals etc.). Authorization is given without reservation or compensation.

_____ _____

Date Signature of Parent/Guardian

Receipt of Notice of Privacy Practices/Written Acknowledgement Form

I, _____, have received a copy of Jessica Wagner Sabo DDS, Inc's Notice of Privacy Practices.

_____ _____

Date Signature of Parent/Guardian

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.

During treatment, it may be necessary for your child to be restrained by you and the office staff to control undesirable movements. Dr. Sabo will 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 muscle fibers causing little bleeding and resulting in a scar-free wound that will heal in one to two weeks.

Dr. Sabo 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 for first night but had no complications. You may choose to give your child over the counter children's pain medication as indicated on the bottle, but it is usually not necessary for most patients. In all the combined experience of skilled dentists using a laser for this surgery, there have been no 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 ages of 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 hereby 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 including redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have been given the opportunity to ask Dr. Sabo 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. Sabo a complete medical history of my child.

_____ _____

Date Signature of Parent/Guardian

_____ _____

Print Name Relationship to Patient