Bridger Children's Dentistry
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FRENOTOMY CONSENT FORM– OLDER CHILDREN

PEDIATRIC INFORMED CONSENT

I, _____, hereby consent for Dr. Nasim Aleagha and her associates to perform the following procedure(s) for my child named _____.

Lingual Frenotomy

Labial Frenotomy (Upper and/or Lower Lip)

I have had the opportunity to discuss the risks, benefits, and alternatives to the proposed above surgical intervention and I provide my written and informed consent to proceed. I understand that all procedures have risks including the possibility of numbness, bleeding, pain, failure of procedure, infection injury to adjacent structures, scarring, and need for revision surgery or additional procedures. I understand that treatment outcomes may vary between patients and underlying circumstance and no guarantees can be made regarding the potential success of the procedure to provide the desired outcomes. Nevertheless, I understand that Dr. Aleagha and her team are fully dedicated to doing everything they can to help me achieve an optimal outcome within the parameters of their scope of practice and office policies.

Furthermore, I also understand and consent to the following:

- I will provide a thorough and complete medical history for my child, supply a full list of medications with dosages, and consent communicating with my other medical practitioners to inquire about any aspect of my child's health history.
- The nature and purpose of the procedure have been explained to me and no guarantee can be made about treatment outcome. I understand that I have the opportunity to inquire about alternative methods of treatment.
- I also consent to the administration of local anesthesia. I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding; swelling; discomfort; nausea; infection; I agree to abide by the post-operative instructions and that my failure to properly care for my child's health may lead to further complications.
- I will pay in full any cost of treatment according to the office's financial policy. I understand that even if insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.
- I am welcome to ask questions about any aspects of my care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of the treatment plan that have not been adequately explained to me.

CONSENT & AUTHORIZATION

I hereby authorize treatment and agree to pay all related professional fees. Fees not covered by my insurance will be promptly paid upon notification form this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Nasim Aleagha. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by: Office Acknowledgement:

Name_____ Date: ___/____/____ Name_____ Date: ___/____/____

Signature_____ Signature_____