AIRSYNC | AIRWAY
Integrative Dentistry

INFORMED CONSENT
Functional Frenuloplasty Child/Adult

I, _____, hereby consent for Dr. Kimberly Santiago, DDS and her team to perform the following procedures:

- ☐ Lingual Frenuloplasty
- ☐ Labial Frenuloplasty (Upper and/or Lower Lip)
- ☐ Buccal Frenuloplasty

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. Santiago 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:

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent communicating with my other medical practitioners to inquire about any aspect of my health history.
2. 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.
3. 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 health may lead to further complications.
4. 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 my treatment plan that have not been adequately explained to me.
5. I have received and reviewed the post-operative care instructions. I understand how to care for my wound and am scheduled accordingly to follow-up with my Myofunctional Therapist.

CONSENT & AUTHORIZATION I hereby do authorize treatment and agree to pay all related professional fees. Without any reservations, I agree to abide by the policies outlined herein.

Form Completed By:
Patient Name_____

Patient/Guardian Signature_____ Date_____

Guardian's Name (if < 18years)_____

Office Acknowledgement
Reviewed/witnessed by:_____ Signature_____