

PNW Tongue Tie

Adult Frenectomy Informed Consent:

I _____ d.o.b. _____ have been informed of the laser frenectomy procedure(s) to be performed. The benefits and possible risks of treatment as well as alternative care options, including no treatment, were discussed and I was provided ample opportunity to have all of my questions and concerns addressed.

Shadi Araghi, DDS will be performing a laser frenectomy to release the physical restriction of the frenum. The intent is to remove the frenum which through reported symptoms, physical exam and written history provides reason for treatment. The expectation is that by removing the frenum there will be an establishment of a more normal lip and/or tongue posture and movement. The presence of a restricted frenum in this case is most likely a contributing factor for speech, feeding, sleep, or other issues. It is understood that though the intent is to alleviate the problem by frenectomy, there is no guarantee that this will cure the problem and could worsen the problem for a time. I further understand that I am responsible to complete the post-op stretching exercises as directed. This will help assure the best possible result. I am to return to my myofunctional therapist for follow-up guidance and to re-educate the muscles.

Post-op complications may be discomfort, minor bleeding, nerve paresthesia or numbness, reattachment, and less commonly fever and infection.

Signed: _____ date: _____

Doctor signature: _____ date: _____

Witness signature: _____ date: _____