Child Informed Consent

I, _____, hereby consent for Dr. Annie Babb to perform the following procedure(s) for my child: _____.

- ☐ Maxillary Labial Frenectomy
- ☐ Mandibular Labial Frenectomy
- ☐ Buccal Frenectomy
- ☐ Lingual Frenuloplasty
- ☐ Gingivectomy

Location(s):_____

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, poor wound healing, infection, scarring, myofascial dysfunction, failure of procedure, injury to adjacent structures, and need for revision surgery or additional therapeutic interventions or procedures at my own expense.** I understand that treatment outcomes may vary between patients and underlying circumstances, and no guarantees can be made regarding the potential success of the procedure to provide the desired outcomes. I understand that Dr. Annie 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.

I also understand and consent to the following:

- I will provide a thorough and complete medical history, supply a full list of my child's medications with dosages, and consent communicating with other medical practitioners to inquire about any aspect of my child's health history.
- The nature and purpose of the procedure(s) have been explained to me and no guarantee can be made about the 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 performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding, swelling, discomfort, nausea, infection, myofascial pain, and/or lingering numbness. 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 am welcome to ask questions about any aspects of my child's care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my child's treatment plan that have not been adequately explained to me.
- I understand that I am responsible for helping my child perform the post-op stretching exercises as directed and failure to complete these exercises may lead to poor healing, scar formation, and wound reattachment which may require an additional release to be completed in the future.

CONSENT & AUTHORIZATION

I hereby authorize treatment and agree to pay all related professional fees. Fees not covered by my insurance will be promptly paid based upon the pre-determined schedule in my Braces For All Ages, P.C. contract. I have read and understand this document in its entirety, outlining the office policies and financial policies of Dr. Annie Babb and Braces For All Ages, P.C. Without any reservations, I agree to abide by the policies outlined herein.

Form Completed By:

Printed Name:_____Signature:_____Date:_____

Office Acknowledgement:

Printed Name:_____Signature:_____Date:_____