Walla Walla Pediatric Dentistry
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Informed Consent for Oral Surgery – Frenotomy/Frenectomy

Prior to completing any oral care on your infant, Walla Walla Pediatric Dentistry requires your informed consent. It is the philosophy of our practice to provide children with the highest quality of care, in a manner that is pleasant and safe. During treatment on small infants, it will be necessary for your infant to be swaddled to control undesirable movements. In some instances, it may be necessary for Dr. Stacey to numb the surgical area using a small amount of local anesthetic and to use a mouth prop to provide adequate visibility and access to the surgical area. Older children may require some form of oral premedication, which if needed, will be discussed prior to having the child sedated. The purpose of these procedures is to gain and maintain good oral health, help to improve breastfeeding, reduce maternal discomfort, reduce infant symptoms, and in many instances prevent future problems that may be associated with tongue and/or lip ties. Dr. Stacey expects good results, however, as in all areas of medicine, results cannot be guaranteed and all consequences cannot be anticipated. Post-surgical discomfort may be minimal or last as long as a week. Bleeding is always a possibility with this procedure as well. Parents should understand recommended procedures, alternative options, and anticipated results. All tongue and lip tie releases in this office are completed using CO_2 laser technology, which has been proven safe for all patients, including infants, and all safety precautions are utilized, including eye protection. Successful results of this surgery are dependent on parents carefully following all post-operative recommendations, including keeping the surgical sites from healing together, seeing their lactation consultant, and if indicated, a cranial-sacral therapist.

Acknowledgement of Informed Consent

I hereby acknowledge that I have been fully informed of the treatment considerations and 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 my infant will be treated while I remain in the consultation or reception room. I have been given the opportunity for a thorough discussion and to ask Dr. Stacey all the questions I have about the proposed surgical treatment. I hereby authorize Dr. Stacey, assisted by dental auxiliaries, to perform upon my child, the aforementioned oral surgery procedure. By signing this consent, I indicate that I have legal authority to grant this permission. I also agree to pay all fees previously discussed with the practice's Administrative Assistant and have given Dr. Stacey a complete medical history for my child.

_____ _____
Child Name Birthdate

_____ _____
Signature of Parent/Guardian Date

_____ _____
Doctor Signature Date

During surgical procedures, our office takes photographs or videos of pre-treatment and post-treatment cases. Your child will not be identifiable in these photos. We would like your consent to use these for educational purposes, such as sharing with other professionals to advance breastfeeding medicine. By signing below, you consent to sharing the photos and videos with other professionals.

_____ _____
Signature of Parent/Guardian Date