CONSENT FOR LIP REPOSITIONING SURGERY

I,_____hereby authorize Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer to perform a lip repositioning procedure on myself.

Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer has advised me that I have significant gum display when I smile and he has outlined in detail the different contributing factors that lead to that including but not limited to teeth and jaw bone anatomy and gum discrepancies. I understand that that I have been informed about other treatments available to me if I do present with any of the above discrepancies, such treatments may include: surgery of the jaw, orthodontic treatment with braces and surgical crown lengthening for trimming of the gum as well as restorative solutions such as porcelain veneers or crowns. However, lip repositioning surgery is an elective procedure that will help minimized my gum display at smile.

In order to treat this condition, Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer has recommended that lip repositioning procedure be performed in the inner aspect of my upper lip. The purpose of a lip repositioning procedure is to reduce or shortening the distance between the inner aspect of my lip and the existing gum so that the lip is restricted when I smile and thus, my lip will not rise as high as it does now.

Some patients do not respond successfully to lip repositioning procedure. It means that sometimes the lip still rises as high as it does now, for which my Dr. may consider a re-entry procedure or redo the procedure if necessary. I understand that the success of the surgery relies on my individual healing response and compliance to the post-operative instructions and to follow-up appointments and I have not been given any promises that such procedure will work in my case. I also understand that unforeseen conditions may call for changes in the anticipated surgical plan. I understand that I consent to any such changes as deemed necessary in the opinion of Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer.

I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to infection, bleeding, swelling, pain, temporary discoloration of my face, increased tooth sensitivity and/or lack of nerve sensitivity and tightness on my upper lip. The duration of complications cannot be determined, and complications may be irreversible.

I understand that even though therapy and surgery are performed, there is still a risk of failure of the therapy and surgery that there is a risk of relapse.

I consent to photographs and x-rays of my oral and facial structures and also give my permission for their use in educational and scientific purposes, including publication.

I certify that Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer has fully informed me regarding the nature of my periodontal condition and the therapy and surgery to be performed, that I have read and fully understand the contents of this document and that Drs. Pomerantz/Arguello/Neugebauer/Marcuschamer has answered all questions that I have relating to my condition.

_____ _____

(Signature of patient or legal guardian) (Witness to signature)

_____Date