

Infant/Child Frenectomy Parent Consent

I acknowledge that the doctor has explained my child's condition and the proposed frenectomy procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I was able to ask questions and raise concerns with the doctor about my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that photographs or video footage may be taken during my child's procedure and these may be used for educational or marketing purposes. (Your child will not be identified in any photo or video). I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE.

Name of Patient AND Parent: _____

Signature of Parent/Substitute decision maker:

_____ Date: _____

For the Office: _____

