

**PENINSULA CENTER FOR IMPLANTOLOGY**

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**GUM REPOSITIONING Procedure:**

I understand that I will be having Lip Repositioning surgery; I understand that this is a purely cosmetic procedure. I accept the risk of any possible complications that may occur due to that fact.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**RISKS RELATED TO THE SUGGESTED TREATMENT:** While this could be considered a low risk procedure, risks related to gum repositioning might include post-operative bleeding, swelling, pain, infection, facial discoloration. Risks related to the anesthetics might include, but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of the injection of the anesthetics. I understand that relapse, either partial or full could occur which would require further surgery to correct. I also understand that there is a risk that my lip line could be uneven.

**SUPPLEMENTAL RECORDS & THEIR USE:** I consent to photography, filming, recording and x-rays of my oral structures, as related to these procedures and for their educational and/or marketing use in lectures or publications, provided my identity is not revealed.

**NO WARRANTY OR GUARANTEE:** I hereby acknowledge that no guarantee or warranty has been given to me that the proposed surgery will be completely successful in altering my lip line; however it is anticipated (hoped) that the surgery will provide benefit to my over all cosmetic lip line appearance. But due to individual patient differences, one cannot predict the absolute certainty of the results therefore, there exists the risk of failure, unevenness, selective re-treatment or worsening of my present condition.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_