



**CONSENT FORM:
BONE GRAFTING**

Part 1 - Patient & Doctor Information

Patient Name: _____

Date : _____

Doctor Name: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Part 2 - Details of Consent

Condition

My doctor has explained the nature of my condition to me:
Not enough bone to place a dental implant securely.

Procedure - Bone Grafting in area # _____

My doctor has proposed the following procedure to treat or diagnose my condition: Bone grafting. This involves taking a segment of bone from my jaw or using artificial bone and transferring it to the site where the bone is deficient.

Bone graft materials

- Autogenous bone (patient's own bone)
- Alloplastic/Allogenic bone (Synthetic/Derived from the bone bank)

I have been informed and understand that occasionally there are complications of this procedure including, but not limited to:

- Pain and/or swelling.
- Bleeding, bruising and/or discoloration of the face, usually of a temporary nature.
- Numbness and tingling of the lip, chin, gums, teeth, cheek and palate.
- Infection that may adversely affect the new bone and require further treatment.
- Limitation of jaw function.
- Postoperative unfavorable reactions to drugs, such as diarrhea, nausea, vomiting and allergy.

Alternatives

My doctor has explained the following medically acceptable alternatives:

- No treatment (Eliminating the option of using dental implants)
- Dental bridgework or removable partial dentures

Anesthetic

- Local anesthesia only
- Local anesthesia with Intravenous (IV) sedation

Anesthetic risks include discomfort, nausea/vomiting, dizziness and allergic reactions. There may be inflammation at the site of an intravenous injection which may cause prolonged discomfort and may require special care.

Your obligations in intravenous sedation used include:

Since anesthetic medication cause prolonged drowsiness, you must be accompanied by a responsible adult to drive you home and stay with you until you have sufficiently recovered to care for yourself. This may take up to 12 hours.

During the recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions (such as signing legal documents)

IT IS IMPORTANT THAT YOU HAVE NOTHING TO EAT FOR 8 HOURS PRIOR TO YOUR ANESTHETIC (INTRAVENOUS SEDATION)

However, if you are taking regular medications, it is important that you take them, by taking small sips of water. You may drink water up to 2 hours prior to surgery.

Other procedures

During the course of the procedure, your surgeon may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request that my surgeon performs the procedures that he thinks are better to do at this sitting rather than later on.

Risks

My surgeon will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: The graft material not incorporating enough into the jaw, requiring other prosthetic measures.

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, my surgeon has not given me any guarantee that the proposed treatment will be successful, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment.

Part 3 - My Responsibility

I agree to cooperate completely with my specialists recommendations while under his care. If I don't fulfill my responsibility, my results could be affected. Smoking increases the risk of post-operative complications. Therefore, my doctor has recommended that I stop smoking two weeks prior to the scheduled surgical procedure and up to eight weeks following the completion of the procedure. Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, regular follow-up appointments and overall general health.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with my doctor.

Necessary Follow-up Care and Self-Care

Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my surgeon can evaluate and report on the outcome of the surgery upon completion of healing.

Part 4 - Miscellaneous

Fees

I know the fee that I am to be charged. As a courtesy to me, the office staff will help prepare the insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered.

Part 5 - Signature

Understanding

I have read and understand this form. I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at my doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize my doctor to perform the procedure listed in the title above.

I know that I am free to withdraw from treatment at any time.

I give my informed consent that the surgeon can use restraint as deemed required during the procedure.

▶ _____ Date _____
Patient or Representative Signature

If not the patient, what is your relationship to the patient?

▶ _____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

▶ _____ Date _____
Doctor/Witness