INFORMED CONSENT: BONE GRAFTING/SINUS LIFT SURGERY

This form & your discussion with your doctor will help you make informed decisions about your surgery by informing you of your *diagnosis, the planned procedure, the risks, benefits, and alternatives* associated with the procedure and any associated costs.

BENEFITS: When a patient lacks sufficient bone to allow implant placement, bone can be added *to fill in an extraction site,* to *re-build a dental ridge* where bone has resorbed over time, or to *raise the floor of the sinus*. (*sinus lift*). Without bone grafting, successful implant placement may be impossible.

Following careful examination of my medical history as well as my clinical & radiographic conditions, my doctor has informed me that I would benefit from bone grafting procedures in the following location(s):

____

My doctor has explained to me the different sources of bone grafting material, as well as the *risks & benefits* of each & has given me time to have my questions answered. I am satisfied with the type of bone graft to be used during my procedure.

The graft will be taken from (*anatomic location*) or will be banked bone or bone substitute:

____

ALTERNATIVES: I have the right to refuse the proposed treatment. Treatment alternatives have been discussed with me & may include *shorter* or *angled implants, ridge expansion*, *alveoloplasty. Resorbable* or *non-resorbable* membranes (*secured with sutures*) may be needed to prevent soft tissues from encroaching on the newly placed bone.

RISKS: Bone grafting/sinus lift surgery involves potential risks, including, but not limited to:

- **Nerve injury.** Slight possibility of injury to facial nerves & tissues of the oral cavity. Surgery or use of local anesthetic may cause temporary (or rarely, *permanent*) *numbness of lips, tongue, floor of the mouth, and/or cheeks.*
- **Local anesthetic complications.** Local anesthetic risks include, but are not limited to: *swelling, bruising (including facial), soreness, elevated blood pressure or pulse, allergic reaction, interaction with drugs I take* & *altered sensation* that may lead to *self-injury*. *Partial* or *complete numbness* can be *transient* & in rare cases, *permanent.*
- **Infection.** Infection, possibly serious, may interfere with treatment success. It is the patient's responsibility to report swelling, especially accompanied by fever or malaise, to this office.
- **Related Complications.** *Inflammation of blood vessels, injury to adjacent teeth, bone fracture, sinus penetration, delayed healing, allergic reactions,* etc. No method can accurately predict healing or final bone volume; additional bone grafting procedures may be needed.
- **Bisphosphonate drug risks.** I have informed my doctor of past &/or present use of drugs like *Fosamax, Actonel, Boniva,* etc. for treatment of osteoporosis/metastatic bone cancer. I understand that past use of these drugs (even 10 or more years prior) can *increase the patient's risk of osteonecrosis* or *failure of bone to heal properly* following sinus lifts and/or bone grafting procedures.

- **Smoking, alcohol intake or diabetes.** I agree to follow my doctor's pre-op & post-op instructions regarding these factors; I understand that smoking, alcohol & a history of diabetes can negatively affect healing & limit success of bone grafting/sinus lifts.
- **Possibility of Failure.** Bone grafts can fail due to rejection, non-union of the graft to the recipient bone, and/or failure of the graft. Graft removal, reconstructive surgery & alternative prosthetic procedures, at additional fees, may be required.
- **Follow-up Treatment.** Following sinus lift surgery or bone grafting procedures I will schedule and keep regular periodic examinations as instructed by the treating dentist(s) or staff.
- **Unusual reactions to medications given or prescribed.** Adverse reactions to ***medications*** or ***treatment materials*** may cause an *allergic reaction or nausea, vomiting, disorientation, confusion, lack of coordination,* prolonged *drowsiness.*

PATIENT RESPONSIBILITIES:

CONFIRMATION OF MEDICAL HISTORY:

YES / NO History of taking bisphosphonates for ***metastatic bone cancer;*** Treatment year: __________
YES / NO History of taking bisphosphonates for ***osteoporosis:*** (*i.e. Boniva, Fosamax, Actonel, Reclast*, etc.)
YES / NO Radiation treatment to the head or neck area
YES / NO Bleeding problems
YES / NO Taking blood thinner medications or daily aspirin
YES / NO Taking anticoagulants (i.e. *Coumadin, Plavix, Lovenox, Fragmin, Angiomax*)
YES / NO Predisposed to food allergies, asthma or hives
YES / NO Pregnant, recent pregnancy or nursing
YES / NO History of taking *phenytoin, PHT, mephenytoin, valproate, phenobarbitone, vigabatrin, primidone*
YES / NO History of taking *cyclosporin, sirolimus, tacrolimus, ethosuximide*

A **responsible adult, over age 18, will drive me to & from the doctor's office on the day of the procedure & will stay with me until I am recovered sufficiently to care for myself.**

I can read and write English & have carefully reviewed the above information. I have been given ample time to discuss with my doctor, the *nature, purpose, risks, benefits* & *fees* associated with the *recommended treatment* & *treatment alternatives,* including non-treatment. All my questions have been answered to my satisfaction. I voluntarily assume any & all possible risks, including the risk of substantial harm, which may be associated with treatment in hopes of obtaining the desired result.

By signing this form, I am freely giving my consent to authorize the doctors and staff to render any services they deem necessary or advisable to treat my dental conditions.

I have provided this office with an accurate & complete medical & personal history, including any allergies & all current medications. I agree to allow all recommended diagnostic procedures, including x-rays & to follow all treatment and post-treatment instructions. No guarantees or warranties have been made to me concerning treatment results. I understand this treatment can also be performed by an oral surgeon or a periodontist (*dental specialists*). I understand the risks & agree to proceed with the recommended treatment at this office. If I am sedated during the procedure, I authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

I understand that if any unexpected difficulties occur during treatment, I may be referred to a specialist (*oral surgeon, periodontist, etc.*) for further care.

_________________________________ _______________________________ _______________
Patient's Name *Patient/Parent/Guardian Signature* *Date*

_________________________________ _______________
Doctor's Signature *Date*

_________________________________ _______________
Witness Signature *Date*