DENTAL SPECIALTY CENTER
FALCON

BONE GRAFTING & PERIODONTAL REGENERATION OF DENTAL IMPLANTS

Patient name: _____ **Date:** _____

INFORMED CONSENT: My doctor has informed me of a diagnosis of **peri-implantitis,** an inflammatory condition which has progressed to the bone supporting the implant. Without treatment, I understand this condition can lead to implant failure and the need for the implant to be surgically removed and replaced. I understand that this disease can occur due to a number of factors including *poor oral hygiene, smoking, a suppressed immune system, genetic factors* and *underlying medical conditions* such as diabetes.

I have been informed that once disease has spread to the bone supporting the implant, surgical treatment is necessary to save the implant. I understand that successful surgical treatment will depend greatly on my ability to maintain impeccable oral hygiene, to keep my scheduled periodontal maintenance appointments and to present for regular clinical and radiographic examinations so that potential issues may be identified at an early stage. I acknowledge that smoking inhibits wound healing and increases the risks of treatment failure. I understand that despite excellent surgical technique, follow-up care, and my doctor's best efforts, not all surgeries are successful & my implant may be lost.

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*

TREATMENT SITE(S): My doctor has recommended **periodontal regeneration procedures** in the following sites to treat my **peri-implantitis:**

_____

PERI-IMPLANTITIS TREATMENT: I understand that my doctor will make a **surgical incision** *(which may be closed with sutures – stitches)* to gain access to the implant so that its surface can be ***cleaned & decontaminated.*** I have been informed that **decontamination procedures** could involve the use of ***laser therapy, medicated rinses, and/or mechanical cleaning of the implant surface***. In addition, I understand that **bone recontouring and/or bone grafts**, with or without the placement of a **membrane,** may be indicated, depending upon my specific clinical conditions.

BONE GRAFTING: Following careful review of my radiographs and clinical conditions, as well as a thorough knowledge of my medical & dental history, my doctor has informed me that **bone grafting procedures** are indicated to address bone destruction caused by **peri-implantitis.** Bone grafting will be performed in the following location(s):

_____ **BONE GRAFTING SITE(S):** _____
Patient initials

_____ **BONE GRAFTING MATERIAL(S):** _____

Patient initials

SURGICAL RISKS. I understand that this surgical procedure involves potential risks, including but not limited to:

- **Nerve injury.** There is the slight possibility of temporary or permanent injury to the nerves of the face and oral cavity during surgery which may result in *numbness of lips, tongue, floor of the mouth, and/or cheeks.*
- **Infection.** In spite of how carefully surgical sterility is maintained, post-operative infection can interfere with the success or longevity of the bone graft and ultimate implant success.
- **Related Complications**. Thrombophlebitis *(inflammation of blood vessels),* injury to adjacent teeth present, bone fracture, sinus, penetration, delayed healing, allergic reactions to drugs or medications used, etc. may occur. I understand that there is no method to accurately predict the healing capabilities of the gums and/or bone in any patient, including myself. I understand that bone remodels while healing and there is no method to predict its final volume. Additional bone grafting may be necessary to achieve the desired final results.

SURGICAL RISKS.

- **Bisphosphonate drug risks.** I understand that if I take or have taken bisphosphonate drugs for treatment of osteoporosis, or have had them administered *at any time* in the past for treatment of **metastatic bone cancer,** there is an increased risk failure of bone to heal properly following any surgical procedure involving bone including bone grafts.
- **Smoking, alcohol intake or diabetes.** I understand that these factors may adversely affect the healing process, limiting the resulting success of the **peri-implantitis regeneration and/or bone grafting procedures.**

ANESTHESIA:

I elect to have the following type(s) of anesthesia administered *(as indicated by my initials):*

_____ Local Anesthesia	**_____ Nitrous Oxide (Laughing Gas)**	**_____ Oral Conscious Sedation**
_____IV Conscious Sedation	**_____Deep Sedation (General Anesthesia)**	

LOCAL ANESTHESIA RISKS: Local anesthetic is used to numb the teeth & tissues to ensure patient comfort. Though generally very safe, side effects & complications can occur. My doctor has discussed with me the risks associated with local anesthetic administration and I understand that they include, but are not limited to the following:

- *Tenderness redness, irritation, facial bruising at the injection site*
- *Changes in heart rate*
- *Nerve & blood vessel injury; transient numbness in the lips, tongue, chin, gums, cheeks & teeth*
- *Tissue injury from biting/chewing numb tissues*

Uncommon side effects and complications of local anesthetics include: failure of local anesthetic to work effectively*);* infection at the injection site requiring antibiotics & further treatment; damage to surrounding structures such as *blood vessels, nerves & muscles*; dizziness; nausea/vomiting; increase/decrease in heart rate; allergic reaction; tingling sensation/numbness in the lips, tongue, chin, gums, cheeks & teeth, which is transient but on rare occasions may be permanent; local anesthetic overdose, broken needles requiring removal, seizures, heart & breathing complications that may lead to brain damage, stroke, heart attack *(cardiac arrest)* or death.

POST-OPERATIVE INSTRUCTIONS: I will follow all instructions given regarding use of antibiotics & medications & have been advised of risks associated with prescription pain medications (*drowsiness, potential for addiction & a lack of awareness & coordination*) – effects which may be intensified with the use of **alcohol, tranquilizers, sedatives**, or **other drugs**. I will not operate any vehicle/machinery until I have recovered from the effects of medications & drugs.

NITROUS OXIDE: I understand that if I choose to have surgical treatment performed under nitrous oxide sedation, that I will be given the opportunity to discuss the risks & benefits of these options with my doctor, including the additional fees involved & special post-operative considerations before signing a **separate consent form.**

ORAL SEDATION/IV SEDATION/GENERAL ANESTHESIA: I understand that if I choose to have surgical treatment performed under **oral conscious sedation** or **IV conscious sedation** or **general anesthesia** that I will be given the opportunity to discuss the risks & benefits of these options with my doctor, including the additional fees involved & special post-operative considerations before signing a **separate consent form.** I agree not to have anything to eat or drink *(other than a small sip of water to take my medications)* for at least six (6) hours prior to my procedure and agree to be accompanied by a responsible adult who will drive me to and from my doctor's office and stay with me until I have recovered adequately to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate machinery/devices, or make important decisions *(signing documents, etc.).* If I am sedated or under general anesthesia during the procedure, I authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

INFORMED CONSENT: I attest that my **medical history**, including all past & present ***prescription & non-prescription medications, medical conditions, recreational drug use, pregnancy*** *(if applicable),* ***allergies*** *&* ***hospitalizations***, is current and accurate. I have informed my doctor of all past issues with *local or general anesthesia, abnormal bleeding* & *unusual reactions to pollens & dust*.

I have informed my doctor if I am being treated or have been treated in the past *(including the distant past)* with **bisphosphonates.** I understand that the use of **tobacco & alcohol** is detrimental to the success of my treatment. I agree to *follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, & keep all appointments.* I will contact this office right away if complications arise. I understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization, at additional expense, may be required. I understand that any fees related to replacement of a failed implant are my sole responsibility.

I have had ample opportunity to discuss & ask my doctor questions regarding this procedure & am satisfied with the ***nature, purpose, risks, benefits* & *fees*** associated with **peri-implantitis regeneration & bone grafting procedures.** I understand that I am free to refuse this treatment. I have carefully read and understand the contents of this form and consent to proceed with peri-implantitis regeneration, including bone grafting procedures and any other procedure decided upon to be necessary or advisable in the opinion of the doctor. No guarantees regarding the outcome of this procedure have been provided to me. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

Patient or Legal Representative Signature: _____ **Date:** _____

Print Patient or Legal Representative Name/Relationship: _____

Doctor: _____ **Date:** _____

Witness: _____ **Date:** _____