

## INFORMED CONSENT: RIDGE AUGMENTATION

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**DIAGNOSIS.** After careful examination and study of my medical history and dental conditions, my doctor has advised me that I have bone loss in an **edentulous** (*missing teeth*) area of my mouth which will negatively affect the esthetics and function of planned restorative treatment. This form and my discussion with my doctor will allow me to understand the *purpose, risks, benefits, alternatives and fees* associated with **ridge augmentation** procedures.

**RECOMMENDED TREATMENT.** Based upon my specific clinical conditions, as well as my esthetic and functional desires, my doctor has recommended that a **ridge augmentation procedure** be performed to increase available bone:

to allow implant placement at the same time as ridge augmentation surgery

to allow implant placement at a later date (*usually 6-9 months later*)

to improve esthetics for a fixed bridge (*pontic(s) will replace missing tooth/teeth*)

Other: \_\_\_\_\_

**TREATMENT SITE(S).** The site(s) of the planned ridge augmentation surgical procedure:

\_\_\_\_\_

**TREATMENT.** Ridge augmentation will be performed under **local anesthetic**. If **nitrous oxide, oral sedation, IV sedation or general sedation** are administered, I understand that I will be given an opportunity to discuss the risks, benefits and additional fees associated with these options and to have my questions answered prior to signing a **separate informed consent**.

My doctor will create an incision to gain access to damaged bone, which will be closed afterwards with sutures (*stitches*). Bone irregularities may be reshaped with a bur and defects will be filled in with **bone graft materials**.

**GRAFTING MATERIALS.** My doctor has discussed with me the available types of bone grafting materials which include *my own bone, animal bone material (cow or pig), synthetic grafting materials or bone obtained from tissue banks (human donors)*. To help prevent soft tissues from invading the graft site, a **synthetic membrane or collagen wafer membrane** may be used.

The following **bone grafting & membrane** materials are planned for use in my **ridge augmentation procedure**:

\_\_\_\_\_

**TREATMENT ALTERNATIVES.** I understand that I am under no obligation to proceed with **ridge augmentation surgery**, but that delaying or refusing recommended treatment could negatively affect future restorative treatment outcomes. Alternatives to ridge augmentation surgery may include: (1) no treatment; (2) dental bridgework; (3) removable partial dentures; (4) no tooth replacement;

**RISKS OF RIDGE AUGMENTATION SURGERY.** I have been informed that complications that may result from surgery could involve the **surgery procedure, bone regenerative materials, drugs, or anesthetics**. These complications include, but are not limited to *post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums*.

The exact duration and reversibility of any complication cannot be predicted. There may be a need for a 2nd procedure if the initial results are not satisfactory.

**NO WARRANTY OR GUARANTEE.** No guarantee, warranty or assurance has been given to me in regard to the proposed surgical procedure. Despite my doctor’s technical skill and very best of care, not every patient responds successfully to the bone regenerative procedures used in **ridge augmentation surgery**. I understand that the success of surgical procedures is affected by a patient’s *medical conditions, dietary and nutritional status, smoking, alcohol consumption, tobacco use, clenching and grinding of teeth, oral hygiene levels, and medications*.

**FOLLOW-UP/SELF-CARE:** I understand that it is my responsibility after ridge augmentation surgery to return for recommended post-operative checkups (*according to the recommendations of my doctor*). I have informed my doctor of all pertinent medical conditions, allergies, and any over-the-counter medications that I’m taking. I have been informed that smoking, poor oral hygiene and excessive alcohol use have a very negative effect on wound healing.

Initials: \_\_\_\_\_

**MEDICAL HISTORY.** To my knowledge, I have reported to my periodontist any *prior drug reaction, allergies, diseases, symptoms, habits or conditions* that might in any way relate to this surgical procedure. I realize there is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that **poor glycemic control** associated with **diabetes** can result in poorer surgical outcomes. I understand that my diligence in providing the personal, daily care recommended by my periodontist and taking all medications as prescribed are important to the success of the procedure.

**CONFIRMATION OF MEDICAL HISTORY:**

YES	NO	History of taking bisphosphonates for <b>metastatic bone cancer</b> ; Treatment year: _____
YES	NO	History of taking bisphosphonates for <b>osteoporosis</b> : ( <i>i.e. Boniva, Fosamax, Actonel, Reclast, etc.</i> )
YES	NO	Radiation treatment to the head or neck area
YES	NO	Bleeding problems
YES	NO	Taking blood thinner medications
YES	NO	Taking daily aspirin
YES	NO	Taking anticoagulants ( <i>i.e. Coumadin, Plavix, Lovenox, Fragmin, Angiomax</i> )
YES	NO	Predisposed to food allergies, asthma or hives
YES	NO	Pregnant, recent pregnancy or nursing

**INFORMED CONSENT:** I can read and write English and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment (**ridge augmentation surgery**) and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. I have been informed of my diagnosis, the planned procedure(s), the risks, benefits and alternative treatments associated with this procedure. If I elect to have any additional forms of anesthesia other than local anesthetic, I agree to review and sign **separate informed consents**.

By signing this form, I am freely giving my consent to allow and authorize Dr. \_\_\_\_\_ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

**Patient name (printed):** \_\_\_\_\_



Patient/guardian name (*signature*): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient:  Self; \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_