Consent for Bone Graft Surgery

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY
UNDERSTAND ITS CONTENTS

I have been informed and afforded the time to fully understand the purpose and the nature of the bone graft surgery procedure. I understand what is necessary to accomplish the placement of the bone graft under the gum on/or in the bone.

My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire a bone graft to help secure the replaced missing teeth.

I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are thrombophlehitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

I understand that if nothing is done any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done an inability to place a bone graft or implants at a later date due to changes in oral or medical conditions could exist.

My doctor has explained that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft. **It has been explained that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.**

It has been explained that in some instances bone grafts fail (mal-union, delayed union, or non-union of the donor bone graft to the recipient bone site) and must be removed. Lack of adequate bone growth into the bone graft replacement material could result in failure. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of the results of treatment or surgery can be made. I am aware that there is a risk that the bone graft surgery may fail, which might require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. If the bone graft surgery fails I understand that alternative prosthetic measures may have to be considered.

I understand that excessive smoking, alcohol, or blood sugar may effect gum healing and may limit the success of the bone graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

I agree to the following procedures:

☐Autogenous graft - which transplants bone from one region of the patients body to another.

Donor Sites:

☐Chin (mental symphysis) lower arch

☐Edentulous area

☐Maxillary tuberosity site

☐Ascending ramus

☐Iliac crest

☐Tibia

☐Other_____

Recipient Site:

☐Upper Arch

☐Lower Arch

☐Edentulous Area

☐Sinus

☐Allograft - which transplants bone from one individual to a genetically non-identical individual of the same species (cadaver bone). All tissue allografts procured meets stringent specifications during donor screening and laboratory testing to reduce the risk of transmitting infectious disease. All tissue allografts are processed from donors found to be negative by FDA approved tests for Human Immunodeficiency Virus (HIV), Hepatitis, Syphilis, West Nile Virus, Severe Acute Respiratory Syndrome (SARS), and the neurological condition Creutzfeldt-Jakob disease (CJD). The processing of tissue allograft products consists of a strict, quality-controlled procedure which involves thorough cleaning of all tissue as well as gentle dehydration with solvents. The process leaves virtually no deleterious residue and eliminates nearly all antigenic properties. Although efforts are made to ensure quality, most tissue banks make no claims concerning the biological or biomechanical properties of provided allograft. All allografts have been collected, processed, and distributed for use in accordance with the Standards of the American Association of Tissue Banks.

Donor:

☐Demineralized freeze-dried bone (DFDB)

☐Freeze-dried bone (Puros Cancellous Particulate Allograft)

Recipient Site:

☐Upper arch

☐Lower arch

☐Edentulous area

☐Sinus

☐Alloplast - implantation of synthetic/ chemically derived bone substitutes or membranes.

Donor:

☐Dense HA Recipient

☐Resorbable HA Site

☐Collagen membranes

☐Other_____

Recipient Site:

☐Upper Arch

☐Lower Arch

☐Edentulous Area

☐Sinus

I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more or until fully recovered from the effects of the anesthesia or drugs given for my care.

To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to he performed for the advancement of implant dentistry, provided my identity is not revealed.

I agree to notify the doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (two to four weeks).

With clear knowledge of all of these possible complications, have requested that the procedure be performed in the:

□Office environment

□Hospital environment

I request and authorize medical/dental services for myself, including bone grafts and other surgery. I fully understand the contemplated procedure, surgery, or treatment conditions that may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the bone graft procedure.

Signature of Patient or Guardian_____

Date_____

Signature of the Doctor_____

Date_____