

Consent For Bone Graft Surgery

1. 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.
2. 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.
3. 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 thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. 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.
5. 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.
6. 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.
7. I understand that excessive smoking, alcohol, or blood sugar may affect 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.
8. I agree to the following procedures:
Autogenous graft - Which transplants (your) bone from one region to another.

Donor Sites:

- Chin (mental symphysis) U Upper 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 allografts are processed from donors found to be negative by FDA approved tests for HBsAg, anti-HBc, anti-HCV, STS, antiHIV 1/2, and anti-HTLV-I. 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 Recipient(DFDB)
- Freeze-dried bone

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

9. (For Mild-Moderate sedation) 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.

10. 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.

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

12. 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).

13. 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.

14. Will the surgery hurt?

There is always some discomfort with any surgery. You will be given local anesthetics (e.g. Novocaine). You can expect to be comfortable during the procedure. Reactions to these anesthetics are rare, but please let us know if you have ever had a reaction. Prescriptions for oral medications will be given for discomfort following the procedure. Most patients are comfortable with mild pain medications. A few patients will have moderate to severe discomfort that requires stronger medication.

Antibiotics are sometimes prescribed. If you are a female on oral contraceptives, they may be less effective at preventing pregnancy. You should consider additional protection at this time. Patients who smoke or have a habit of grinding or clenching their teeth tend to have greater discomfort.

15. What will the first week be like? During the first 24 hours after surgery, you should take it easy and apply ice inside your mouth and cold compresses to the outside of your face according to the directions we will give you. Keeping the surgical area cold the first day will help keep down swelling. Slight bleeding is common after surgery and you will be given instructions on how to manage it.

Don't be afraid to take the recommended medications. If you take them exactly as prescribed, your post operative complications and discomfort will be minimal. Always call the doctors if you develop a rash or reaction to any medications. Never take over-the-counter pain medications with your prescriptions unless you check with the doctors.

Slight swelling and bruising are common. The medications should keep you comfortable, but if you are not, please be sure to contact the doctors. Most patient can return to their normal functions the day following the surgery, but a small percentage of patients may take a few days to feel able to return to regular activities.

16. Healing period and timing: A 4-9 month of healing will be required. Any discomfort is a concern and should be brought to our attention. After 9-12 months the benefits of the graft start to reverse. If an implant is anticipated, it must be placed within the recommended time frame.

Signature of Patient or Guardian _____

Date _____

Signature of Witness _____

Date _____

Signature of the Doctor _____

Date _____