Consent for the use of

Bone (Ridge) Augmentation Procedures

Patient Name: ____

Area(s) to be treated: ____

This consent for treatment is given the attending doctor after having first been fully informed of the diagnosis, the proposed treatment, treatment alternatives and risks.

Diagnosis. After a careful oral examination and study of my dental condition, my Periodontist has advised me that I have insufficient available bone in this area of my jaw. I understand that additional bone is needed to increase the bone volume in this area to allow implant placement and/or to improve support for future prosthetic treatment.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include bone augmentation surgery. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics may be used.

During this procedure, my gum tissue will be surgically moved back to permit better access to the bone.

Graft material will be placed in the areas of insufficient bone. Various types of graft materials may be used. These materials may include my own bone, which is taken as a block of bone from the front (chin) of my lower jaw, synthetic bone substitutes, or bone obtained from tissue banks (allografts). I have been informed the type of bone graft material which will be used and have had an opportunity to ask questions. Membranes will likely be used with the graft material. My gums will be sutured back into position over the above materials.

I further understand that unforeseen conditions may call for a termination of the procedure prior to completion of all the surgery originally outlined.

Expected Benefits. The purpose of the bone augmentation surgery is to increase the amount of bone in my jaw. The surgery is intended to allow future placement of dental implant(s) or allow placement of prosthetic appliances.

Principal Risks and Complications. I understand that some patients do not respond successfully to bone augmentation procedures. The procedures may not be successful in increasing the amount of jaw bone needed. Because each patient's condition is unique, additional surgeries may be necessary.

I understand that complications may result from the surgery involving bone augmentation materials, drugs or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling, and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanently increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, cracking or bruising of the corners of the mouth, restricted ability to open mouth for several days or weeks, adverse impact on speech, allergic reactions, and accidental swallowing of a foreign matter. In the event the donated tissue is use for the graft, the tissue has been tested for hepatitis, syphilis, and other infectious diseases. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how I will heal. I understand that there may be a need for a second procedure if the initial surgery is not entirely successful. In addition, the success of bone augmentation procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of the teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge I have reported to my periodontist my prior drug reactions, allergies, diseases, symptoms, habit, or conditions which might in any way relate to this surgical procedure. 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 ultimate success of the procedure.

Alternatives To Suggested Treatment. Alternatives to bone augmentation surgery include: (1) no treatment--- with the expectation that dental implants or prosthetic appliances will not be placed. (2) the use of soft (gum) tissue to increase the tissue thickness in this area. This will not allow implants to be placed and prosthetic appliances may not be able to be placed.

Necessary Follow-up Care and Self-Care. I understand that it is important for me to continue to see my regular dentist. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following the surgery so that healing may be monitored and so that the periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to abide by the specific prescriptions and instructions given by my periodontist.

Use of Records for Reimbursement Purposes. I authorize photos, slides, x-rays, or other viewings of my care and treatment during or after its completion to be used for the reimbursement purposes.

PATIENT CONSENT

I have been fully informed of the nature of bone regenerative surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of bone regenerative surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional and alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT DESCRIBED ABOVE. I ACCEPT THE RISKS OF HARM IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULTS OF THIS TREATMENT.

Patient Signature ____ Date _________________________

Legal Guardian (if patient is under 18 years of age) ____

Signature of attending doctor ____

Signature of Witness ____