Consent for Tooth Extraction with Bone Grafting

Patient Name*:* _____

An explanation of your need for extraction and bone grafting in the socket by the use of freeze-dried allograft bone and guided tissue regeneration, their purpose and benefits, the surgery related to this procedure, and the possible complications as well as alternatives to its use were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

SUGGESTED TREATMENT: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me. I have been informed that in areas of my jaw where I will be having teeth removed, there would be benefit to simultaneous bone grafting to help prevent bone loss.
The tooth/teeth to be removed are: Tooth #___ Teeth #_____

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw bone surface, teeth are removed, the extraction sites are cleansed of any infected tissue, the graft material placed into the extraction sockets and on the surface of the bone and then a membrane may be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration and to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth, over the bone graft and membrane. Part of the membrane will be exposed.

DESCRIPTION OF THE GRAFT MATERIAL: Freeze-Dried Mineralized Bone Allograft- this is human bone tissue donated by the next of kin of deceased persons. All donors are screened by physicians and other health care workers to prevent the transmission of disease to the person receiving the graft. They are tested for hepatitis, syphilis, blood and tissue infections and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes the process of freeze-drying.

RISKS RELATED TO THE PROCEDURE: Risks related to surgery with extraction and ridge bone regeneration by the use of bone grafts might include, but are not limited to: fracture of the tooth/teeth during extraction, dislodging of a tooth or part of a tooth into the upper jaw sinus, post-surgical infection, bleeding, swelling pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic result. (2) Building up the ridge with soft tissue grafting which would not increase the possibility of using dental implants. (3) Extending the depth of the cheek pouch by surgery with or without the use of a soft tissue graft which would not increase the possibility of using dental implants or the esthetics or phonetics related to design of a fixed bridge.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infection, or further bone loss or gum recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for modification or change from the anticipated surgical plan. These may include, but are not limited to extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of the surgery.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give consent for the performance of any and all procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

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 _____

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