253 DENTAL CARE

Dentistry Dedicated to Excellence

Consent for Bone Graft Surgery

I, _____, hereby authorize Dr. Mark Walker to perform the

following procedure:_____ .

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. The doctor has also informed
me that there are certain potential risks associated with this treatment plan or procedure that may occur despite the experience and skill of the doctor.

I UNDERSTAND that BONE GRAFT SURGERY includes possible inherent risks such as, but not limited to the following and I agree to accept any and all such risks:

1. Purpose: I understand that bone graft surgery is intended to replace lost bone for
reconstructive or esthetic purposes. I acknowledge that alternatives to these procedures have been explained to me. I realize that consequences of not having the bone graft surgery or sinus lift surgery could be but are not limited to: infection or loss of bone, infection or loss of gum tissue, infection, sensitivity of teeth, looseness of teeth leading to the need for extraction, etc. I acknowledge if the bone graft surgery and/or sinus lift procedures are not performed, it may not be possible in the future to place implants or a bone graft due to changes in my oral or medical conditions.

2. Bleeding, bruising, swelling: Bleeding may last several hours. If bleeding is profuse,
you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time

3. Infection: In spite of how carefully surgical sterility is maintained, it is possible,

because of the existing non-sterile environment, infections may occur postoperatively. At times these may be of a serious nature. Should severe swelling occur, particularly when accompanied with fever or malaise, attention should be received as soon as possible. It is the patient's responsibility to contact this office should the foregoing occur. Such infection may interfere with the success or longevity of the bone graft and ultimate success of the implant.

4. Injury to the nerves: There is the slight possibility of injury to the nerves of the
face and tissues of the oral cavity during administration of local anesthetic or during surgery which may cause numbness of lips, tongue, floor of the mouth, and or cheeks, etc. This numbness may be of a temporary or, rarely, permanent, in nature.

5. Excessive smoking, alcohol intake or diabetes: These factors may adversely affect the
healing process, limiting the resulting success of the bone graft and/or sinus lift procedure.

6. Related Complications may include thrombophlebitis (inflammation of blood vessels),
injury to adjacent teeth present, bone fracture, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc. I understand that there is no method to accurately predict the healing capabilities of the gums and/or bone in each patient, including myself, following the placement of a bone graft. I understand that bone remodels while healing and there is no method to predict the ultimate or final volume of bone. In some cases following healing, additional bone grafting may be necessary to achieve the final results desired.

7. Possibility of Failure: I understand that in some instances bone grafts fail due to
mal-union, delayed union or non-union of the donor bone graft to the recipient bone site and must be removed. I understand that lack of adequate bone growth in to the bone graft replacement material may also result in failure of the graft. It is possible that reconstructive surgery may be necessary associated with and/or following removal of the graft. I understand that alternative prosthetic procedures may be required should the bone graft fail.

8. Follow-up Treatment: It is absolutely necessary following sinus lift surgery or the
placement of bone grafts to have regular periodic examinations. The patient must assume the responsibility to make appointments and report as instructed by the treating dentist(s) or staff.

9. Unusual reactions to medications given or prescribed: Reactions, either mild or
severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions.
Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective.

Other methods of contraception must be utilized during the treatment period.

10. Bacterial Endocarditis: Because of normal existence of bacteria in the oral cavity,
the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. Pre-existing conditions causing valvular dysfunction are the most likely cause of this complication. It is my responsibility to inform the dentist of any heart problems known or suspected.

11. Bisphosphonate drug risks: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone, including sinus lifts and/or bone grafts.

12. I recognize that it is my responsibility to fully inform my treating dentist(s) of
the condition of my health and any and all problems thereto. It is also my responsibility to timely seek attention should any undue circumstances occur postoperatively. I agree to diligently comply with any and all preoperative and postoperative instructions given me.

I have been given the opportunity to ask any questions regarding the nature and purpose of this treatment known as **Bone Graft** and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial 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 treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. Walker to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize Dr. Walker to perform such procedures when, in their professional judgment, they are necessary. I also verify that I have provided a complete and accurate medical history that includes all medications, drug use, allergies, previous surgeries, and pregnancyinformation and history.I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. It has been explained to me and I

understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____

Patient, parent or guardian

_____ _____

Doctor Date