ABSOLUTE DENTAL CARE
Family, Reconstructive & Implant Dentistry
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Informed Consent For Bone Grafting Procedures (Page 1 of 3)

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing

Name: _____ Date: _____

____ I. 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 thromhophlehitis (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. It also has been explained to me 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 effect gum and bone 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 bone from one region to another.

Donor Sites: ____Mental Symphysis ____Edentulous Area
____Maxillary Tuberosity ____Ascending Ramus ____Tibia

Recipient Site: ____Upper Arch ____Lower Arch ____Sinus ____Extraction Socket(s)

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ALLOGRAFT - Which transplants bone from one individual to a genetically non-identical individual of the same species (cadaver bone). 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 (DFDBA) ____Freeze-dried bone(FDBA)
____Irradiated Bone

Recipient Site: ____Upper arch ____Lower arch ____Sinus ____Extraction Socket(s)

ALLOPLASTS, XENOGRAFTS, TISSUE-ENGINEERED GRAFT - Implantation of natural or synthetic/chemically derived bone substitutes or membranes.

Recipient Site: ____Upper Arch ____Lower Arch ____Sinus ____Extraction Socket(s)

____9. 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.

____10. I consent to the administration of anesthesia, including local, intravenous, inhalation, and/or general anesthesia in conjunction with the procedure(s) referred to above and to the use of such anesthetics as may be deemed advisable by Dr. Koos and his associates or assistants. I understand that all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs like the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.

____11. Medication, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

____12. No guarantee or assurance has been given to me that the purposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that worsening of my condition could occur without the recommended treatment.

____13. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems and/or injuries.

____14. I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that lack of the same could result in a less than optimum result.

____15. I agree to grant consent to any and all additional procedures necessary, either elective or emergent, that may arise during or after my surgery, while I am physically unable to grant consent due to anesthesia or impairment, in order to complete treatment or to treat a complication that has arisen during surgery or anesthesia.

____16. The fee for services has been explained to me and is satisfactory.

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____ 17. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any oral surgery treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

____ 18. I request and authorize medical/dental services for myself, including bone grafting 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 procedure.

____19. 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.

____20. 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).

____21. With clear knowledge of all of these possible complications, I have acknowledge that the procedure be performed in an outpatient office environment.

____22. I certify that I speak, read and write English and as such, have read and fully understand this consent for surgery.

Signature of Patient or Guardian_____ Date_____

Signature of Witness_____ Date_____

Signature of the Doctor_____ Date_____