Woodstock General & Implant Dentistry
121 Route 375
Woodstock, NY 12498

(845) 679-3706
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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 under the 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 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 durations 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 neck and facial muscles, and tired muscles when chewing. In addition, Im aware that if nothing is done an ability to place a bone graft or implants 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 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 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 healing and may limit the success of the bone graft. I agree to follow my doctors homecare instructions. I agree to report to my doctor for regular examinations as instructed.

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8. I agree to the following procedures: Donor Site:

☐ Chin (mental symphysis) ☐ Edentulous area ☐ Maxillary tuberosity

☐ Ascending ramus ☐ Iliac creast ☐ Tibia

☐ Other_____

I agree to the following procedures: 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 allograft are processed from donors found to be negative by the FDA approved tests for HBsAg, Anti-HBc, Anti-HCV, STS, and Anti-HTLV-I. Although efforts are made to ensure quality, most tissue banks make no claims concerning the biological or biochemical properties of provided allograft. All allograft have been collected, processed, and distributed for use in accordance with the standards of the American Association of Tissue Banks.

◯ Yes ◯ No

Donor

☐ Demineralized freeze-dried bone (DFDB) \ ☐ Freeze-dried bone

Recipient site

☐ Upper arch ☐ Lower arch ☐ Edentulous area ☐ Sinus

Alloplast- Implantation of synthetic/chemically derived done substitutes or membranes

Donor

☐ Dense HA ☐ Resorbable HA ☐ Collagen membranes

☐ Other_____

Recipient site

☐ Upper arch ☐ Lower arch ☐ Edentulous arch ☐ Sinus

9. 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 form 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, pollen, dust, blood or body diseases, gum, or

skin reactions, abnormal bleeding or another condition 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 implants dentistry, provided my identity is not revealed.
12. I agree to notify the doctors office of any and all changes to my address and/or phone number within a reasonable time frame (two to four weeks).

◯ Yes ◯ No

13. With clear knowledge of all of these possible complications, I have requested that the procedure be performed in the:
    - Office environment
    - Hospital environment

14. I request and authorize medical/dental services for myself, including bone grafts and other surgery. I fully understand the contemplated procedure, surgery or treatment condition that may become apparent which warrant, in judgment of the doctor, additional, 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, assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the bone graft surgery.

☐ This is my consent for the doctor, or any dentist to physician who may be employed by Tischler Dental:

To perform the oral dental procedures indicated on my examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned operation.

I also agree to the use of local, conscious, or general anesthetic sedation, and analgesia, depending upon the judgment of the dentist of the dentist/physician involved with my care.

I have been informed that occasionally there are complications of the treatment, drugs, and anesthesia, including pain, infection, swelling, bleeding , discoloration, numbness, tingling of the lip, tongue, chin, gums, cheeks, and teeth, pain and numbness and tingling thrombophelebitis (inflammation of the vein), form intravenous injection, injury to and stiffening of the neck and facial muscles, referred pain to the ear, neck, and head, nausea, vomiting, allergic reaction, bone fractures, bruises, or delayed healing.

Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination which can increase by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices, or work, while taking such medications and/or drugs, or until fully recovered from the effect of the same. I understand and agree not operate any vehicle or hazardous device for at least 24 hours, or until fully recovered from the effects of such medications, drugs, or anesthetics.

Because of these conditions, it has been thoroughly explained to me and I completely realize that any surgical procedure may therefore, be classified as a risk procedure. The risk involved is defined as a greater possibility of experiencing morbidity (the relative incidence of disease) and mortality (the proportion of death to population), during surgical

procedure than a person in good health. These complications which can occur during surgery may involve more then average amount of post-operative discomfort, increased pain and swelling, and delayed healing. I fully acknowledge that these possible complications have been explained. With clear knowledge of all these possible complications, I have requested that the procedure be performed in the:- Office environment - Hospital environment
I may request further explanations of the risk involved and possible outcome of the procedure. When the patient is a minor or incompetent to give consent, signature should be of a person authorized to consent for the patient.

◯ Yes ◯ No

Response Date: