Consent for Dental Bone Graft Surgery

I have been informed and I understand the purpose and the nature of the bone graft surgery procedure. I understand it is being done to enhance the shape of the bone in my jaw.

My dentist 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 involved teeth.

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 injury to other teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

I understand that if nothing is done, any of the following could occur: faster progression of gum disease, loss of more bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, and loss of teeth.

My doctor has explained that there is no method to accurately predict the gum and the bone healing capacities in each patient following the placement of the bone graft, and the final volume of bone that will be attained, thus additional grafting or corrective procedures may be necessary later. It has been explained that in some instances bone grafts fail and must be removed, in which case alternative prosthetic measures may have to be considered.

I have been informed and understand that Dentistry, as with any health care discipline, is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

I understand that smoking, alcohol, undiagnosed or uncontrolled medical conditions may affect gum healing and may limit the success of the graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

I agree to receive local dental anesthetic.

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, previous surgical complications, or any other conditions related to my health.

I agree to the following procedures:

___ *Autogenous graft (autograft)* – Bone transplanted from one region to another.
Donor sites:
__Chin
__Edentulous area _____
__Maxillary tuberosity
__Ascending ramus
__Iliac crest
__Tibia
__Other _____
Recipient site:
__Upper arch in area of _____
__Lower arch in area of _____
__Around teeth # _____
__Around implants # _____
__Maxillary sinus

___ *Allograft* – Bone transplants from one individual to a genetically non-identical individual of the same species (cadaver bone). All allografts are processed from donors found to be negative by FDA approved tests for HBsAg, anti-HBc, anti-HCV, STS, antiHlV 1/2, and anti-HTLV-I. Although efforts are made to ensure quality, the sterility of the graft material is provided by the manufacturer and not the dentist. 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 (DFDB)
__Freeze-dried bone
Recipient site:
__Upper arch in area of _____
__Lower arch in area of _____
__Around teeth # _____
__Around implants # _____
__Maxillary sinus

___ *Xenograft* – Bone transplants from non-human species. These contain only the sterilized non-organic materials, which acts as a scaffold for the body to replace the graft with natural bone. Although efforts are made to ensure quality, the sterility of the graft material is provided by the manufacturer and not the dentist.
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__Demineralized freeze-dried bone (DFDB)
__Freeze-dried bone
Recipient site:
__Upper arch in area of _____
__Lower arch in area of _____
__Around teeth # _____
__Around implants # _____

__Maxillary sinus

___ *Alloplast graft* - Implantation of synthetic/ chemically derived bone substitutes or membranes.
Donor:
__Dense HA
__Resorbable HA
__Barrier membrane _____
__Other _____
Recipient site:
__Upper arch in area of _____
__Lower arch in area of _____
__Around teeth # _____
__Around implants # _____
__Maxillary sinus

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I consent to photography, filming, recording, x-rays of the procedure to be performed, and additional professional staff observing the procedure, for the advancement of dentistry, provided my identity is not revealed.

I request and authorize the bone grafting services described above. I fully understand that during, and following the contemplated procedure, surgery or treatment, conditions 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 modification in design, materials, or care, if it is felt this is for my best interest.

_____ _____

Signature of Patient Date

_____

Signature of Parent (if patient a minor)

_____

Witness

_____

Relationship to Patient