Informed Bone Graft/Site Preservation Consent Form

SUGGESTED TREATMENT:
I have been informed of the need for bone grafting/site preservation to allow for the proper placement and positioning of dental implants and/or to preserve the bone area.

DESCRIPTION OF THE PROCEDURE:
After anesthetics have numbed the area to be operated, the gum is reflected from the jaw bone surface, the graft material placed 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 and/or together.

DESCRIPTION OF THE GRAFT MATERIAL:
Bone can be used from a few different sources. Bone can be harvested from other areas of your mouth. Alternatively, an allograft can be used. 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 demineralization of the bone and its preservation by the process of freeze-drying. In addition, bone processed similar to the above descriptions after harvesting from bovine sources can be used as well as artificial bone-like substances.

RISKS RELATED TO THE PROCEDURE:
Risks related to surgery with bony regeneration by the use of bone grafts might include, but are not limited to: 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:
I understand that depending on my diagnosis, alternatives to extraction may exist which involve other disciplines in dentistry. I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

NO WARRANTY OR GUARANTEE:
I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in building adequate bone for implant placement. Due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-treatment, or worsening of my present condition, despite the best of care.
CONSENT TO UNFORSEEN CONDITIONS:
During surgery, unforeseen conditions could be discovered which would call for a 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 my 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.

☐ I give my consent to the proposed treatment as described above by Dr. Chad Lyew.
☐ I refuse to give my consent for the proposed treatment as described above.
☐ I have been informed of and accept the consequences if no treatment is administered.

_____________________________________________          _________________
Patient’s Signature                                      Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to extraction with ____________________(patient’s name) who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____________________________________________          _________________
Dentist’s Signature                                     Date

_____________________________________________          _________________
Witness’ Signature                                      Date