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INFORMED CONSENT FOR BONE REGENERATIVE SURGERY

Diagnosis: After a careful oral examination, radiographic evaluation and study of my dental condition, my periodontist has advised me that I have bone loss where there is a missing tooth/teeth. This lack of bone leaves an unaesthetic or poor functioning area for dental crown(s)/bridgework and does not allow the placing of dental implants.

Recommended Treatment: In order to treat this condition, my periodontist has recommended that my treatment include bone regenerative surgery (ridge augmentation). I understand that a local anesthetic will be administered as part of the surgery and that antibiotics and other medications may be given. During this procedure, my gum will be opened to permit better access to the eroded bone. The following treatment will be performed:

- Inflamed and infected gum tissue will be removed and root surfaces will be thoroughly cleaned.
- Bone irregularities will be reshaped.
- Bone regenerative material (grafting) will be placed in the areas of bone loss.
- My gum will be sutured back into position and a periodontal dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to: **(1)** extraction of hopeless teeth to enhance healing of adjacent teeth, **(2)** the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or **(3)** termination of the procedure prior to completion of all of the surgery originally outlined.

Bone Graft Materials: Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Sometimes sterile, medical grade calcium sulfate is mixed with the bone in order to provide a good source of extra calcium content for obtaining a successful bone graft. A covering (i.e. medical grade, resorbable sterile collagen membrane) may be used to keep the bone graft material in place while it heals.

Expected Benefits: The purpose of bone regenerative surgery is to restore my gum and bone to the extent possible for better esthetics and function. It also may allow dental implant placement to be more achievable.

Principle Risks and Complications: I understand that some patients do not respond successfully to bone regenerative surgery. The procedure may not be successful in preserving function, appearance, or allowing a dental implant to be placed. Because each patient's condition and each area is unique, long-term success may not occur.

I understand complications that may result from the surgery could involve the bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to: post-surgical infection; bleeding; swelling and pain; facial discoloration; transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum; jaw joint injuries or associated muscle spasm; transient but on occasion permanent increased tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth; cracking or bruising of the corners of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; and accidental swallowing of foreign matter. In the event that donated tissue is used for the graft, the tissue should have been tested for hepatitis, viral, bacterial and other infectious diseases. Nevertheless, there is a remote possibility that tests will not determine the presence of such diseases in a particular instance. The exact duration of any complications cannot be determined and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of bone regenerative surgery and dental implant procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

In view of the foregoing, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: Alternatives to bone regenerative surgery includes: **(1)** no treatment; **(2)** dental bridgework; **(3)** removable partial dentures; and **(4)** no teeth replacement.

(OVER)

Necessary Follow-Up Care and Self-Care: I recognize that natural teeth and appliances should be maintained daily. I understand that it is important for me to return for follow-up appointments for care and monitoring of the healing process. I also need to continue to see my general dentist for routine dental care and get the missing tooth/teeth replaced as recommended. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I should not use a water-pik in the bone graft site for three months. Failure to follow the recommendations regarding my bone graft(s) could lead to ill effects, which would become my sole responsibility.

To my knowledge, I have told my periodontist about any pertinent medical conditions, allergies (especially to medications or sulfites) and medications I am taking, including over-the-counter medications such as aspirin.

I know that it is important to: **(1)** abide by the specific prescriptions and instructions given; **(2)** see my periodontist for post-operative check-ups as needed; **(3**) not smoke or use smokeless tobacco for at least two weeks; **(4)** avoid water-piks for three months; **(5**) have any non-dissolvable sutures and/or membranes removed; and **(6)** get the tooth/teeth replaced as recommended.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use an additional form of birth control along with my birth control pills for one complete cycle after a course of antibiotics is completed.

Administration of Local Anesthetic: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs until fully recovered from their effects.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases it should be, however, due to individual patient differences there can never be a certainty of success. There is a risk of failure and complications, such as those previously mentioned, despite the best of care.

Communication with Insurance Companies and Dental/Medical Providers: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carrier(s), the doctors' billing agency, my general dentist, and any other health care provider involved with my case who may have a need to know about my dental treatment.

PATIENT CONSENT

I certify that I have been fully informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, the necessity of notifying my periodontist of any pertinent medical conditions and of any prescription/non-prescription medications I am taking and that there are no guarantees. I have had the opportunity to ask questions in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of bone regenerative surgery as presented to me during my consultation and as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE I SIGNED IT AND CONSENT TO BONE REGENERATIVE SURGERY.

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Signature of Patient (Parent/Guardian) Date

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Printed Name of Patient (Parent/Guardian)

_____ _____

Signature of Witness Date

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Printed Name of Witness