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CONSENT FOR SINUS LIFT PROCEDURE WITH BONE REPLACEMENT GRAFT

I authorize and request my periodontist to perform surgery on my upper jaw (maxilla).

I understand that the surgery will be performed to place a bone graft material below the floor of the sinus to build up adequate bone height for the placement of implants. The bone graft will consist of bone particles (your own bone and/or substitute bone). At the same time, or in a few months after the graft has partially healed, a second procedure will be done to insert the implants into the upper jaw and the grafted material. It is expected that the implants will become stable and act as anchors for crowns or fixed-detachable bridges or dentures.

My periodontist has explained that if the new bone does not incorporate into the bone graft material, alternative prosthetic measures will have to be considered. My periodontist has explained and described the procedures to my satisfaction.

The likelihood for success of the suggested treatment plan is good. However, there are risks involved. The bone graft material has produced good results when placed on upper and lower jaws. The bone graft replacement material has previously been shown to be free from rejection or infection. However, there is no guarantee that your graft will not become infected or be rejected following surgery.

I have been informed and understand that although rare, there are complications from the surgery, drugs, and/or anesthesia used including, but not limited to:

1. Pain, swelling, and post-operative bruising of the face, neck, and mouth.
2. Numbness or tingling of the upper lip or lower lip, chin, gums, teeth, cheek, or palate, which may be temporary or rarely permanent.
3. Infection of bone that might require further treatment including hospitalization and surgery.
4. Malunion, delayed union, or nonunion of the bone graft placement material to form normal bone.
5. Lack of adequate bone growth into the bone graft replacement material.
6. Bleeding which may require extraordinary means to control hemorrhage.
7. Limitation of jaw function.
8. Stiffness of facial and jaw muscles.
9. Injury to the teeth.
10. Referred pain to the ear, neck, and head.
11. Post-operative complications involving the sinuses, nose, nasal cavity, sense of smell, infraorbital regions and altered sensations of the upper cheek and eyes.

12. Post-operative unfavorable reactions to drugs, such as nausea, vomiting, and allergy.

13. Possible loss of teeth and bone segments.

I understand that I am not to use alcohol during the treatment period. My periodontist has discussed with me that smoking is particularly harmful to the success of this operation. I have been recommended to stop smoking.

I understand that my periodontist will give their best professional care toward the accomplishment of the desired results. I understand that I can ask for a full recital of all possible risks involved in phases of my care. I further understand that I am free to withdraw from treatment at any time.

I give permission for persons other than the periodontist involved in my care and treatment to observe the operation and to photograph it for purposes of teaching and research.

I understand this consent form. I request my periodontist to perform the surgery discussed.

***PLEASE LIST ALL MEDICATIONS/DRUGS TAKEN IN THE LAST 24 HOURS.**

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Yes☐ No☐ If you are a female and taking birth control pills: By signing below I certify that when taking an antibiotic, I must use other forms of birth control for up to one month after finishing the antibiotic.

Yes ☐ No☐ If you have taken or are taking bisphosphonate medications: By signing below I certify that I have been informed of and accept any risks I may have due to the use of these drugs.

Yes☐ No☐ If you are a regular blood donor or plan to donate in the future please be aware that donor agencies may not accept your blood if you have bone grafting material placed during this procedure. (Please inform us of your future plans)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ _____

Date Print Name and Signature of Patient, Parent or Guardian

_____ _____

Date Print Name and Signature of Witness

_____ _____

Date Dr. William E. Mason/Dr. Monica A. Lamble