Provider: Dr Ash **CONSENT FOR BONE GRAFTING**

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Patient's Name Date

During your consultation we discussed your need for bone grafting surgery, steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure**. Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page.**

_____ 1. I understand that a bone grafting procedure is indicated for my condition to:
□ Increase bone volume for placing a dental implant □ Preserve bone volume after dental extraction
□ Other: _____

_____ 2. Based on my condition, my doctor's knowledge and clinical experience the following bone grafting procedure has been
selected for me:

□ A. NON-AUTOGENOUS BONE GRAFTING. One or more of the following bone graft materials maybe used: (1) Processed Bone Allograft- 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. Tissue is recovered and processed under sterile conditions. Processing includes preservation of the bone by the process of freeze-drying. (2) Bone processed similar to the above descriptions after harvesting from bovine (cow) sources. (3) Artificial bone-like ceramic or mineral substances. The bone graft is applied to the site(s) where bone support has been determined to be deficient (usually for placing a dental implant).

□ B. AUTOGENOUS CORTICAL BONE GRAFTING. This involves taking a segment of bone from the front of the chin area or the wisdom tooth area and transferring it to the site(s) where bone support has been determined to be deficient (usually for placing a dental implant). In situations where larger quantities of bone are required, bone may be taken from both portions of the jaw on either or both sides.

_____ 3. I have been informed of possible alternate methods of treatment including:
□ No Treatment □ Alternate treatment (if any): _____

_____ 4. I understand that these other forms of treatment, or no treatment at all are choices I have and the risks of those choices have
been presented to me.

_____ 5. Possible risks and side effects associated with my proposed treatment include, but are not limited to:

A. Post-operative discomfort, swelling and bruising requiring several days of at-home recovery.
B. Prolonged or heavy bleeding that may require additional treatment.
C. Injury or damage to the blood supply of teeth adjacent to the graft donor site. That may require root canal treatment of affected tooth, or even result in their eventual loss.
D. Post-operative infection that my adversely affect the new bone graft and require additional treatment.
E. Scarring at the site of incisions inside the mouth.
F. Osteomyelitis, a chronic bone infection may occur at either the donor or recipient graft site. Long term antibiotic therapy or other treatment may be needed
G. Screws or wire may be used to anchor the bone graft. Premature loss of the screws or wires may result. In such cases, they must be removed and loss of the bone graft may occur.
H. Fracture of the jaw (very rare).
I. Injury to sensory nerves in either donor or recipient sites, resulting in numbness, tingling, pain, or other sensory disturbances in the chin, lip, cheek, face, teeth, gums or tongue, and which my persist for several weeks or months, or rarely may be permanent. Accidental penetration of the sinus or nasal cavity may occur, requiring additional medication or surgical treatment.
J. The bone graft material may fail to integrate with natural bone resulting in failure of the graft. Additional bone grafting may be necessary to obtain sufficient bone volume.

K. The chance of viral or bacterial disease transmission from processed (Non-Autogenous) bone is always a very remote possibility (very rare).

L. In the case of an autogenous cortical graft, natural particles of donor bone, or other forms of synthetic bone are often packed around the cortical graft to supplement it. These particles may also become devitalized and be lost, often over some period of time.

M. Biologic/synthetic membranes are often used to contain and protect the graft. Some may require a second procedure to remove them; or some may be unexpectedly lost in which case the graft may be adversely affected.

N. Some grafting procedures are planned in two stages: one to obtain and place the graft, then a second to remove various fixation devices (if any used; i.e. screws, wires, membranes). If planned, dental implants may be placed at the second stage, or weeks or months of further healing may be required before the bone graft is sufficiently mature to place implants.

O. Allergic reactions (previously unknown) may possibly occur to any medications used in grafting procedures.

P. Jaw joint injuries, pain or muscle spasm/stiffness cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, and transient (on rare occasion permanent) increased tooth mobility, sensitivity to hot, cold, sweet, or acidic foods or shrinkage of the gum upon healing. The exact duration of any complication cannot be determined, and may be irreversible.

Q. To my knowledge, I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure. I have also told my doctor about any present or prior head and neck radiation therapy and present or prior use of bisphosphonate medications. Some common brand names are Zometa, Aredia, Boniva, Fosamax, and Actonel.

_____ 6. I understand that I must commit to timely placement of the planned dental implant. If too much time passes, the bone graft
may resorb ("melt away") and the resulting deficient bone will not permit implant placement.

_____ 7. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes
in the procedure noted in paragraph 2A & 2B above. I authorize my doctor and staff to use their professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

_____ 8. No warranty or guarantee. No guarantee, warranty or assurance has been given to me that the proposed treatment will be
successful. Due to individual patient differences there can never be a certainty of success, despite the best of care. I understand, there is no method that will accurately predict or evaluate how the tissue will heal before the surgical procedure. There may be a need for a second surgery if the initial results are not satisfactory.

_____ 9. Use of records for reimbursement and publication purposes. I authorize photos, video recordings, x-rays, slides, or any
other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will <u>never</u> be revealed to the general public.

_____ 10. **Females only.** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the bone grafting procedure, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the bone grafting procedure as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document.

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Patient's Signature (or patient's guardian) Date

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Witness Signature Date