

# Periodontics and Dental Implants

*An explanation of your need for bony ridge augmentation by the use of demineralized free-dried allograft bone and guided tissue regeneration, their purpose and benefits, the surgery related to their placement and the possible complications as well as alternatives to its use were discussed with you at your consultation. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.*

## Consent for Tooth Extraction and Simultaneous Use of Bone Grafting in Conjunction to Attempt Ridge Augmentation

SUGGESTED TREATMENT: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for extraction have been explained to me. The tooth/teeth to be removed are checked below:

Upper Right																	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right																	Lower Left

I have been informed that in areas of my jaws where I will be having teeth removed, there would be benefit to the support of conventional dental prosthetics or for the anchorage of dental implants if simultaneous bone augmentation is performed.

**DESCRIPTION OF THE PROCEDURE:** After anesthetics have numbed the area to be operated, the gum is reflected from the jawbone surface, the graft material is placed on this surface and then covered by a Guided Tissue Barrier Membrane the purpose of which is 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:** (1) Bone tissue harvested from other areas of your mouth. (2) Demineralized 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. They are tested for hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes preservation of the bone by the process of freeze-drying. (3) Bone processed similar to the above descriptions after harvesting from bovine sources and (4) Artificial bone-like ceramic or mineral substances.

**RISKS RELATED TO THE PROCEDURE:** Risks related to surgery with ridge 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 spasm, 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:** These may include: (1) no treatment, with the expectation of a less than satisfactory dental prosthetic result; (2) building up the ridge with soft tissue grafting which would not increase the possibility of using dental implants; (3) extending the depth of the cheek pouch by surgery with or without the use of a soft tissue graft which would not increase the possibility of using dental implants or the esthetics or phonetics related to design of a fixed bridge.

**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 eradicating pockets, infection or further bone loss or gum

recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

**CONSENT TO UNFORESEEN 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 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.

**PATIENT'S ENDORSEMENT:** My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to osseous regeneration by the use bone grafting as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient's Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date