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Consent for Bone Grafting Procedure (Banked Bone or Bone Substitutes)

Patient Name: _____ **Date:** _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

I have been informed by my doctor that my current condition and recommendation for treatment *(i.e., implant, sinus lift, cleft palate, orthognathic, etc.)* includes bone graft and membrane using banked bone (freeze-dried, lyophilized, demineralized, xenografts) or bone substitutes. In addition to the risks of the primary surgical procedure that have been explained to me separately, I understand that bone grafting itself involves specific risks. My doctor has explained to me that such risks include, but are not limited to, the following:

RISKS:

_____1. Bleeding, swelling, infection, scarring, pain, numbness or altered sensation (possibly permanent) at the surgical site that may require further treatment.

_____2. Allergic or other adverse reaction to the drugs used during or after the procedure.

_____3. Rejection of the bone graft material.

_____4. The remote chance of viral or bacterial disease transmission from processed bone.

_____5. I agree that I have been given verbal and written postoperative care instructions.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English.

My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature **Date**

Doctor Signature **Date**