Consent for Sinus-Lift with Bone Grafting Procedures

Patient Name: _____ **Date:** _____

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

_____1. My surgeon has informed me of my diagnosis (condition) which is described as: Deficient bone in the upper left /right maxillary sinus areas. The surgical procedure proposed to treat the condition has been explained to me and I understand it to be: Right/Left maxillary sinus lift with bone grafts.

_____2. I understand that there is not enough natural jawbone in which to place the proposed implant(s) and that a procedure called "sinus lift" is planned. The procedure involves making incisions inside my mouth and then opening the sinus cavity in my upper jaw and placing a bone graft. The purpose of this procedure is to provide support for the subsequent implant(s). I have been told that this bone graft could come from specially-prepared donated bone, or bone substitute.

_____3. I understand the bone grafts must remain covered by gum tissue for three months or longer, before it can be used for implant placement. There are however situations where the implants can be placed at the same time as the sinus lift procedure.

_____4. I have been informed of possible alternative forms of treatment, if any, including:_____. I understand that other forms of treatment or no treatment at all are choices that I have and the risks and consequences associated with those choices have been explained to me.

_____5. I have been informed of and understand that the potential risks related to this surgical procedure include:

a. Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to teeth that may result in the need for tooth repair or loss.
b. Nerve injury that may occur from the surgical procedure resulting in altered or loss of sensation, numbness, pain or altered feeling in the face cheek, lip, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time but in some cases may be permanent.
c. Discharge from the nose

RISKS OF FREEZE-DRIED, DEMINERALIZED OR OTHER BANKED BONE

Use of such bone may involve separate risks including, but not limited to:

_____ a. Rejection of the donated graft material together with the entire graft.
_____ b. The remote chance of disease transmission from processed bone.

_____6. I am aware that local anesthesia has potential risks and complications; swelling, bleeding, bruising and possible nerve injury, usually temporary causing prolonged numbness and discomfort in the injected areas. I consent to the administration of **local anesthesia / nitrous oxide / IV anesthesia**.

_____7. It has been explained to me that in the course of the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure, a different procedure from those set forth above, or abandonment of the procedure entirely. In such an event, I authorize my doctor and his or her team to perform such procedures as are necessary and desirable in the exercise of professional judgment to complete my surgery.

_____8. I understand smoking is extremely detrimental to the success of sinus lift surgery. I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery, and to make strong efforts to give up smoking entirely.

_____9. It has been explained to me and I understand that a perfect result is not, and cannot be guaranteed or warranted.

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**

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