CONSENT TO TREATMENT – Bone Graft / Extraction

Name______________________________

1. I authorize Dr. _____________ to perform the following recommended dental treatment.

2. I understand that I have been diagnosed with the following problem(s):
   a. Lack of bone structure not permitting the placement of implants and/or
   b. Extraction that requires bone graft in order to place an implant in afterwards.
   c. I understand that the following treatments are recommended:
      Bone graft area__________________________________________
      that involves reflection of soft tissue flaps for access, extraction of the tooth (if required),
      addition of bone _______ and membrane_________ to try to regrow bone.
         i. Prognosis: Good/ Guarded
         ii. Impact on the surgery: smile line, access, smoking, health, anatomy
         iii. X-ray required: ___________________________________________
   d. This procedure can also be conducted under oral sedation or intra-venous conscious sedation.
   e. This treatment may include the use of local anesthetic, antibiotics, analgesics, sutures (stitches) and a wound dressing if required.

3. I was also informed of the following alternate treatments:
   a. No surgery but then we might not be able to place the implant.

4. The anticipated length of treatment, although I realize that it may vary greatly between patients
   and may be influenced by my own level of cooperation and participation and the availability of
   clinical appointments, and may be delayed by unforeseeable clinical and technical setbacks,
   has been explained as follows:
      a. Surgery time: ___________________________
      b. Multiple post-op apts: 7, 14, 21 days for 15 min
      c. Healing time: 6 months

5. I understand that risks related to the recommended treatments may include, but are not limited to
   the following:
      a. Allergic reactions to any dental products, materials and medications
      b. Bleeding and swelling
      c. Infection that might require removal of bone graft material
      d. Opening of the wound that might require more sutures to be placed
      e. Pain
      f. Exposure of the root surface (recession) and/or dentinal hypersensitivity
      g. Exposure of gaps between the teeth
      h. Exposure of crown and bridge joints
      i. Temporary restriction of mouth opening
      j. Increase tooth mobility
      k. Possible paresthesia of dental nerves (teeth, lips, tongue, cheeks, palate…)
      l. Fracture of the tooth during the extraction or adjacent restorations
m. Communication between the sinus and the mouth
n. It is possible that a second bone graft surgery will be necessary if the desired quantity of bone is not obtained in the first place.

6. I understand that refusing treatment of my condition may impact on my oral and general health. Consequences may include but are not limited to:
   a. Progression of bone loss
   b. Impossibility to use an implant retained restoration

7. I understand the necessity of maintaining a good oral hygiene for a better healing and the importance post-surgical appointments. I also understand the importance to strictly follow my periodontist’s recommendations. Tobacco and alcohol products may affect healing negatively after periodontal surgeries and may also affect maintenance of surgical results.

8. I understand that I have been given no warranty nor guarantee pertaining to the success of suggested treatment. In most cases the suggested treatment should reduce causes of my periodontal condition and may permit me to keep my teeth for a longer period of time. Because of variations with patients’ home self-oral care and medical health, the periodontist cannot positively predict the success of provided treatments. Even with optimal treatments, there are always risks of failure which may require re-treatment. The risks of degeneration of my periodontal condition may be still present and may lead to loss of teeth.

9. I authorize the use of photography, radiography and/or any other documentation, which pertains to care and treatment that I received, to be used for promoting advancement in dentistry. However, my identity will never be shown or discussed to public without my written consent.

10. I CERTIFY THAT I COMPLETELY READ THIS DOCUMENT AND THAT ALL MY QUESTIONS WHERE PROVIDED WITH COMPREHENSIVE ANSWERS BEFORE SIGNING THIS DOCUMENT.

(Signature and Date)                                  (Doctor)