Discussion and Informed Consent for Bone Grafting and/or Regeneration

Patient Name: ____ Date: ________________________

Diagnosis: ____

Treatment & Location: ____

Facts for Consideration

Patient's initials required where applicable

_______ I have been informed of the need for bone grafting/site preservation. Bone grafting assists with the growth of bone where the tooth root was previously located and to help prevent bone loss during the healing period (a significant amount of bone resorbtion occurs immediately after the tooth is extracted). The primary purpose of a tooth socket graft is to allow the dental implant placement either at the same time as the surgery or three to six months later. Another purpose of this surgery may be to assist with rebuilding a resorbed ridge for better aesthetics and function where a replacement tooth will be located as part of placing a dental bridge.

_______ I have been informed that I may need a ridge augmentation procedure. A ridge augmentation procedure is often needed prior to implant placement because there is not adequate ridge width for an implant to be placed. Often times the existing ridge width atrophies (narrows) if a significant period of time has passed after extraction. In order to regain ridge width to have adequate bone such that an implant can be surrounded on all sides by bone, a ridge augmentation procedure is required. Another purpose of this surgery may be to assist with rebuilding a resorbed (shrunken) ridge for better aesthetics and function where a replacement tooth will be located as part of placing a dental bridge.

_______ I have been informed that I have periodontal (gum and bone) problems and/or disease that should be surgically treated, including the use of bone grafting and techniques for bone regeneration. I understand that the purpose of this procedure is to allow access for the removal of bacteria by cleaning the roots of teeth and the lining of the gums. Bone grafting may treat irregularities of the jawbone so that when the gum is replaced about the teeth, reduction of gum pockets, infection, inflammation and improved bone healing may occur. The decrease in gum pocket depths is important because it will improve the ease and effectiveness of my personal oral hygiene and the ability of a dental professional to better clean my teeth. The decrease in infection and inflammation may minimize further loss of bone and gum tissue supporting my teeth, which may aid in longer retention of my teeth in the treated area(s).

_______ I have been advised that bone grafting may be performed in areas of my mouth associated with gum pocketing and/or recession. It has also been explained to me that this is a procedure that may involve surgical grafting of bone by removing a piece(s) of bone from another area of my body, requiring another surgical site, or using commercially made bone graft from another human or animal bone source. The graft material may be used in a block form over a large area or in particulate form for smaller areas.

_______ I acknowledge that I have had an opportunity to discuss these options and my choices with my dentist before consenting to this treatment, procedure or surgery.

You must acknowledge and initial one but not both of the next two paragraphs:

_______ By initialing this paragraph, I acknowledge and state that I do not have any objection to the source or origin of the bone graft material whether it be human or animal.

Or

_______ By initialing this paragraph and its parts, I am stating my objection to the origin of the bone graft material that may be used: No human (☐) No animal (☐)

Benefits of Bone Grafting and/or Regenerative Surgery, Not Limited to the Following:

_______ The goal of bone grafting and or regenerative surgery is to assist or help "grow" bone back ("repair" bone that has been lost due to periodontal (gum) disease) or to possibly allow for dental implant placement either at the same time as this surgery or a later date. Additionally, the purpose of this surgery may be to help build a restorable jaw ridge (bone) for better aesthetics and function where a replacement (artificial) tooth will go as part of a dental bridge.

Risks of Bone Grafting and/or Regenerative Surgery, Not Limited to the Following:

_______ I understand that with surgery there may be postoperative bleeding, swelling, pain, infection, facial discoloration/bruising, possible migration or loss of bone graft material from the surgery site, injury to neighboring or adjacent teeth and/or temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweet or acidic foods. A temporary or permanent numbing of the surgical areas, oral cavity or face may occur affecting my lips, chin and tongue, possibly affecting my sense of taste. I understand that I may see changes in the appearance of my gums. They may be in a different position on the roots or there may be spaces between the teeth that are larger. I understand that my teeth may appear "longer" and my roots may be exposed. I also understand that there may be a need for a second procedure if the initial surgery is not entirely successful.

_______ I understand that I will receive a local anesthetic by injection and/or other medication(s). In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect my ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. *Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury to the oral cavity or face, resulting in loss of feeling of the chin, lips, gums and tongue and partial loss of taste can result from an injection.*

_______ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or if other similar concerns arise.

_______ I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that inform my dentist of all medications and supplements that I am currently taking, which are:

________ I am_ I am not_ _currently or in the past taken bisphosphonates (bone supplementing medication) for the purpose of treating osteoporosis.

_______ I understand that smoking and/or chewing tobacco and/or alcohol intake may affect my ability to have normal gum and/or bone healing and may limit the potential for a successful outcome of my surgery. Smoking may adversely affect the extraction site healing and may cause "dry socket" (an infection of the bone of the socket walls). Smokers are at higher risk for "dry socket" (site infection) and have more dry sockets than nonsmokers. I agree to follow my dentist's instructions related to daily care of my mouth, teeth and gums.

Alternatives to Suggested Treatment:

I understand that alternatives to bone graft and/or regenerative surgery include no treatment, nonsurgical scraping of the teeth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt to further reduce bacteria and tarter under the gum line (gingival margin), dental bridgework, removable partial dentures and no teeth replacement.

Alternatives discussed: ____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above. I understand that it is my responsibility to seek attention should any undue circumstance occur postoperatively and I agree to follow any preoperative and postoperative instructions.

Check the boxes below that apply to you:

Consent

☐ I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.

☐ I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr.- to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

____ ______________________________

Patient or Patient's Representative Date

____ ______________________________

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

____ ______________________________

Dentist Signature Date