deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR BONE REPLACEMENT GRAFT AND RIDGE PRESERVATION

Name: ________________________________ Date: ___________ Tooth: _______

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

EXPLANATION OF DIAGNOSIS: After a careful oral examination and study of my dental condition, the doctor has advised me that a bone graft and ridge preservation is recommended for temporary stabilization and preservation of the existing bone.

RECOMMENDED TREATMENT: Ridge Preservation involves a surgical procedure to reduce bone loss after tooth extraction to preserve the dental alveolus (tooth socket) in the alveolar bone. This minimizes bone loss and allows a better outcome for tooth replacement with an implant or a tooth supported bridge. The hole left by the removal of the tooth will be covered by a protective membrane.

EXPECTED BENEFITS: The purpose of a ridge preservation and bone replacement graft is for the graft material to act as scaffold that will be replaced by your own new bone, thus creating a secure location for an implant. A bone replacement graft may also be used to help prevent bone loss.

GRAFT MATERIAL: Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by various means to be free from contaminants. This signed consent form acknowledges your approval for the doctor to use such materials according to his/her knowledge and clinical judgment for your situation.

ALTERNATIVES TO THE PROCEDURE: Alternatives may include: (1) No treatment, and the expectation that my condition will advance and result in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic result. (2) Building up the ridge with soft tissue grafts, 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 improve the aesthetics or phonetics related to design of a fixed bridge.

PRINCIPLE RISKS AND COMPLICATIONS: I understand that a small number of patients do not respond successfully to bone replacement graft and ridge preservation. No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be of a serious nature. Injury to nerves may cause numbness of the lips or tongue, and tissues of the mouth, cheeks or face. Any numbness may result from surgical procedures or anesthetic administration and could be temporary (days, weeks, or months) or possibly permanent. If you experience severe swelling, particularly if accompanied by fever or malaise, you should seek immediate medical attention. You should diligently follow any pre-operative and post-operative instructions. It is your responsibility to seek attention should any undue circumstances occur post-operatively.

LOSS OF ALL OR PART OF THE GRAFT: While there is a high level of success associated with bone

Initials: ________

and membrane grafting, it is possible that the graft could fail. These conditions include: 1) A block bone graft taken from somewhere else in your mouth may not adhere or could become infected; 2) Despite meticulous surgery, particulate bone graft material could migrate out of the surgery site and be lost; 3) A membrane graft could begin to dislodge. If so, the doctor should be notified. Your compliance is essential to assure success.

SINUS INVOLVEMENT: In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus and may result in sinus involvement as a result of nearby grafting. In this event, you will need to take special medications. Should sinus penetration occur, it may be necessary to have the sinus surgically closed.

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, infections, or further bone loss or gum recession. It is anticipated that surgery will provide benefit in reducing the cause of this condition and produce healing that 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, even with the best of care, there exists the risk of failure, relapse, the need for additional treatment, or worsening of my present condition that includes the possible loss of certain teeth due to advanced involvement.

CONSENT TO UNFORSEEN CONDITIONS: Unforeseen conditions may be discovered during surgery that may 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 the surgical plan 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 **smoking and/or alcohol intake may affect gum healing and may adversely affect the successful outcome of my surgery**. I agree to follow instructions related to my own daily care of my mouth and to the use of prescribed medications. I agree to report for appointments following my surgery as suggested so my healing may be monitored, and the doctor may evaluate and report the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, 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) on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all, procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

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Signature of Patient or Parent/Guardian	Date
Printed Name of Patient	Relationship to Patient
Signature of Witness	Date