ADVANCED DENTISTRY
WITH A GENTLE TOUCH

Consent for the Performance of Sinus Augmentation Surgery

Date

Month Day Year

Email

example@example.com

Consent for the Performance of Sinus Augmentation Surgery on

First Name Last Name

An explanation of your need for sinus augmentation, its purpose and benefits, the surgery involved in this procedure, and the possible complications as well as alternatives were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

PURPOSE OF SINUS AUGMENTATION SURGERY: I am aware that I do not have enough bone to anchor dental implants in the rear areas of my upper jaw where there are teeth missing. I have been informed that the purpose of this procedure is to stimulate the growth of bone in the lower portion of the sinus space above the rear portion of my upper jaw. It has been explained that the purpose of this is to provide adequate bone for the anchorage of dental implants which in turn will provide a foundation for dental prosthetic tooth replacement of teeth missing in my upper jaw.

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw surface so as to gain access to the side of the jaw which forms the side wall of the sinus. Next, a hole in this sinus wall is formed, gaining access to the sinus. Next, the membrane lining the sinus is raised from the bone lining the base of the sinus. Next, a bone graft material is placed into the space between the bone and the elevated sinus membrane. Finally, the gum is repositioned to cover the jaw including the hole into the sinus and is sutured back into place to close this wound.

DESCRIPTION OF THE GRAFT MATERIAL: (1) Bone tissue harvested from other areas of your mouth. (2) Processed Bone Allograft- this is human bone tissue donated by the next of kin of deceased persons. All donors are screened by physicians and other health care workers to prevent the transmission of disease to the person receiving the graft. They are tested of hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes preservation of the bone by the process of freeze-drying. (3) Bone processed similar to the above descriptions after harvesting from bovine sources. (4) Artificial bone-like ceramic or mineral substances.

RISKS RELATED TO THE PROCEDURE: Risks related to sinus augmentation surgery with bone regeneration by the use of demineralized bone allografts may include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, or gum, jaw joint injuries or associated muscle spasms. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) no treatment, with the expectation of: (1) no replacement of missing upper teeth; (2) a less than satisfactory outcome to any form of prosthetic replacement of missing upper teeth; (3) continued advancement of bone loss in the area of missing upper back teeth with possible future erosion into the sinus, i.e., the formation of a hole between the mouth and sinus which could lead to the development of chronic infection in the sinus.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will provide enough bone for dental implant anchorage. It is anticipated that the surgery will provide benefit in producing some bone, but it cannot be reasonably predicted so as to guarantee the nature of the eventual prosthetic solution, i.e., fixed versus removable tooth replacement. Due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, despite the best of care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would 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 the outcome of this procedure or termination of the procedure prior to completion of all of the surgery 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.

Consent for the Performance of Sinus Augmentation Surgery

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth, to the use of prescribed medications and to the limitations in use of current removable partial or full dentures. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of the surgery.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video 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) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to maxillary sinus augmentation surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Signature of Patient or Guardian

Date

Month Day Year

Print Name