9600 Blackwell Road, Suite 101
Rockville MD 20850

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BONE GRAFT PATIENT INFORMATION CONSENT FORM

Diagnosis: After a careful oral examination, radiographic evaluation and study of my dental condition, I have been advised that I have bone loss where missing tooth/teeth are. This lack of bone does not allow the placing of dental implants and/or leaves an unaesthetic/poor functioning area for dental crown(s)/bridgework.

Recommended Treatment: In order to treat this condition, it has been recommended that my treatment include bone regenerative (ridge augmentation) surgery. I understand that oral sedation may be utilized and that local anesthetic (*commonly called Novocain*) will be administered as part of the surgery, antibiotics and other medications may be given. During this procedure, the gums will be opened to permit better access to the bone. Bone irregularities may be reshaped with a dental drill. Bone graft material will be placed in the areas of bone loss. Various types of graft materials may be used.

Bone Graft Materials: The sources of bone graft materials are from your own bone, synthetic bone substitutes, and human donors and/or from bovine (*cow*) or porcine (*pig*) processed in accordance with FDA regulations through FDA approved commercial bone banks/processors. Sometimes sterile, medical grade calcium sulfate (*plaster*) is mixed with the bone. Plaster is inserted and resorbs completely in eight weeks; this is a good source of extra calcium content for obtaining a successful bone graft. A covering may be placed over the bone graft, either a non-resorbable synthetic (*needs to be removed, commonly called a PTFE membrane*), or a medical grade, resorbable sterile collagen (*commonly called collagen barrier*) in a wafer form derived from either bovine (*cow*) or porcine (*pig*) achilleas tendon may be used, depending on the type of bone defect present. The purpose of the barrier is to keep the bone graft material in place. Membranes tend to hold the bone graft material in place while it heals. To hold membrane in place securely, doctor may use small screw to fix the membrane and the screws may or may not be removed after the bone formation and before implant placement. My gum will be sutured (stitched) back into position over the above-mentioned materials. I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include but are not limited to:

1. Placing the dental implant(s) at the same time the bone regeneration surgery is done.

2. Termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of bone regenerative surgery is to "grow" bone back, to hopefully allow dental implant placement either at the same time as this surgery or six to nine months later. Another purpose of this surgery may be to help build a resorbed ridge for better esthetics and function where a fake tooth will go as part of doing a dental bridge.

Principal Risks and Complications: I understand some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function or allowing a dental implant to be placed. Because each patient's condition is unique, long term success may not occur. Complications that may result from surgery could involve the bone regenerative materials, drugs, or anesthetics. These complications include but are not limited to, post-operative infection, bleeding. swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint injuries or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, transient (*on rare occasion permanent*) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. The exact duration of any complication cannot be determined, and they may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. There may be a need for a second surgery if the initial results are not satisfactory. In addition, the success of oral surgery and dental implant procedures can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Periodontist/Oral Surgeon any prior drug reaction, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I fully understand that my diligence in providing the personal daily care recommended by my Periodontist/Oral Surgeon and taking all medications prescribed are imperative to the success of the procedure.

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Alternatives to Suggested Treatment: I understand that alternatives to bone regenerative surgery are as follows:

1. No treatment

2. Dental bridgework

3. Removable partial dentures

4. No teeth replacement

Necessary Follow-Up Care and Self-Care: I fully understand and acknowledge it is important for me to continue to see my regular dentist for routine dental care and to get the missing tooth/teeth replaced as recommended. I fully understand and acknowledge smoking and smokeless tobacco may adversely affect healing and may cause pain and/or poor results, especially if used during the first month. (*If you must smoke, keep it under five cigarettes a day and only smoke the first half of the cigarette and discard the rest. Under no circumstances use smokeless tobacco*). I further understand I should not use a water-pik for three months. I have told the Periodontist/Oral Surgeon about any pertinent medical condition(s) I have, known allergies (*especially to medications or sulfites*) any medications I am taking including over the counter medications such as aspirin, nutritional supplements and/or herbs. I have told the Periodontist/Oral Surgeon about any present or prior head and/or neck radiation therapy I have undergone. I have told the Periodontist/Oral Surgeon about any present or prior use of Bisphosphonate medications. Some common brand names include Zometa®, Aredia®, Boniva®, Fosamax® and Actonel®. I fully understand I need to come back for several post-operative visits so my healing may be monitored and so the Periodontist/Oral Surgeon can evaluate and report on the outcome of surgery to my general dentist. It may be necessary to remove both non-resorbable membranes and non-resorbable sutures used in the bone regeneration surgery. I acknowledge that it is important to:

1. Abide by the specific prescriptions and instruction given

2. See the Periodontist/Oral Surgeon for scheduled post-operative visits as needed

3. Not smoke or use smokeless tobacco for one month as noted above

4. Have any non-dissolvable sutures and/or membranes removed

5. Leave out prosthetics, such as denture, for required period of time

6. Get the tooth/teeth replaced as recommended

No Warranty or Guarantee: I acknowledge no guarantee or warranty or assurance has been given to me that the proposed treatment will be successful. In most cases bone regenerative surgery heals quickly and without incident. Due to individual patient differences, however, there can never be a certainty of success. There is a risk of failure, and complications such as those listed above, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Communication with my Insurance Company, My Dentist or other Dental/Medical. Providers involved with my care: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, the dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (*birth control pills*). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

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Patient Endorsement: I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the Periodontist/Oral Surgeon of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the Periodontist/Oral Surgeon. I have read and understand this document before I signed it.

Patient (Guardian) Signature | Print Name | Date

Dentist Signature | Print Name | Date