

ORANGE PERIODONTICS

AND DENTAL IMPLANTOLOGY

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CONSENT FOR RIDGE AUGMENTATION

An explanation of your need for ridge augmentation by the use of allograft bone and guided tissue regeneration, their purpose and benefits, the surgery related to this procedure, and the possible complications as well as alternatives to its use was 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.

Suggested Treatment: I have been informed that in areas of my jaw where I will be having bone grafting performed, ridge augmentation is needed for the placement and long-term maintenance of dental implants.

Description of the Procedure: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw bone surface, the sites are cleansed of any infected tissue. Bone may be treated as necessary, the graft material placed on the surface of the bone and then a Guided Tissue Barrier Membrane may be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration and to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth and/or together.

Description of the Graft Material:

Bone allograft - This is bone tissue of deceased persons donated by their next of kin. All donors are screened by physicians and other healthcare workers to prevent the transmission of disease to the person receiving the graft. They are tested for hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes the demineralization of the bone and its preservation by the process of freeze-drying. In addition, bone processed similar to the above descriptions after harvesting from bovine sources can be used as well as artificial bone-like substances. Bone tissue harvested from areas of your mouth may also be used.

Risks Related to the Procedure: Risks related to surgery with ridge augmentation by the use of bone grafts might include, but are not limited to: post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

Alternatives to the Procedure: These may include: (1) No treatment, with the expectation that dental implants with the ideal or sufficient dimensions may not be able to be placed or maintained long-term (2) Building up the ridge with soft tissue grafting 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 the esthetics or phonetics related to design of a fixed bridge. (4) Using narrower diameter implants, which may compromise the long-term success of the implants and/or restoration.

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 regenerating the ridge for implant placement. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth or implants. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

Consent to Unforeseen 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 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 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.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake and improper oral hygiene and/or diet 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 and to the use of prescribed medications. 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 tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Patient's Signature

Date

Patient's Name

Signature of Witness

Date