Informed Consent for Bone Grafting

Bone Grafting: The bone grafting procedure involves opening the gums in the area to expose the existing bone. This is then followed by placing bone material in such a manner so as to augment the existing bone both horizontally and vertically. A protective barrier or membrane is then placed over the grafted bone for protection. The gums are then closed over and sutured (stitched) in place to completely cover the bone grafted area. A healing time of 4-6 months is then typically allowed for the bone graft to "take", mature, and integrate with the surrounding native bone. As discussed, the bone graft material and membrane we'll be using is derived from a donor source (animal or human) or synthetic. The materials I use have been documented to be safe and reliable.

Expected Benefits: The purpose of bone grafting in your case would be to increase the width of the existing bone to allow for proper implant placement. It would also help to harmonize the esthetics of the region.

Principal Risks and Complications: Although bone grafting of localized areas to increase the width of existing bone has been shown in clinical studies to be a predictable procedure, a very small number of patients do not respond successfully to the procedure and may require revision procedures to attain the desired result. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

Complications may result from grafting surgery, drugs, or local anesthetics. The exact duration of any complications cannot be determined and they may be irreversible. These complications include but are not limited to: pain, swelling, bruising, infection, bleeding, and injury to neighboring or adjacent teeth, adverse drug reactions and discomfort.

There is no method that will accurately predict or evaluate how your gums and bone will heal. There may be a need for a second procedure if the results are not satisfactory. In addition, the success of surgical grafting procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and certain medications. Accurate reporting of any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that you may have should be reported to me. Also, diligence in maintaining personal daily oral care recommended after the procedure and taking all prescribed medications is important to the ultimate success of the procedure.

Necessary Follow-up Care And Self-Care: Natural teeth should be maintained daily in a clean, hygienic

manner. You will need to come for appointments following the surgery so that healing may be monitored and so that Dr. Wardany can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect healing and may limit the successful outcome of surgery. It is important (1) to abide by the specific prescriptions and instructions given post-operatively and (2) to see your general dentist for periodic examination and preventative treatment.

Costs: The estimated costs for this procedure has already been provided to you.

Patient Consent: I have been fully informed of the surgery to be performed, to my satisfaction. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. I also understand the potential outcome of no treatment in the area - i.e. continued bone loss and possible compromise of adjacent teeth. I realize that during the course of the surgery, the treatment may need to be modified due to existing conditions that are only evident when the surgical site has been exposed. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Wardany. By signing below, I hereby consent to the performance of bone grafting surgery as presented to me and consent to any additional or alternative procedures that may be deemed necessary in the judgment of Dr. Wardany. I agree to be ultimately responsible for payment of the treatment in full on the day of the procedure as agreed to with Dr. Wardany.

Name of Patient ______________________________ Date ________________

Signature of Patient ________________________ Office Initials (Witness) __________