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Consent for Sinus Augmentation Bone Regenerative Surgery

Diagnosis: After a careful examination and study of my dental condition, I have been advised that I have bone loss where some missing tooth/teeth are. This lack of bone does not allow the placing of dental implants.

Recommended Treatment: In order to treat this condition, it has been recommended that my treatment include bone regenerative (sinus augmentation) surgery. Local anesthetic will be administered to me as part of the treatment. Antibiotics and other medications will be given.

During this procedure, the gums will be opened to permit better access to the eroded bone. Bone irregularities may be reshaped with a dental drill. Some bone will be removed to create a window to access the maxillary sinus. Bone graft material will be placed in the areas of bone loss in the floor of the maxillary sinus. Various types of graft materials may be used. These materials may include my own bone, animal bone material (cow or pig) or bone obtained from tissue banks (human donors). Collagen wafer membranes made from the Achilles tendons of animals (cow or pig) will be used, depending on the type of bone defect present. Membranes tend to hold the bone graft material in place while it heals. My gum will be sutured back into position over the above 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 ridge augmentation bone regeneration surgery is done, or 2) termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of sinus augmentation bone regeneration surgery is to "grow" bone back to hopefully allow dental implant placement either at the same time as this surgery, or 9 months later.

Post-operative instructions: I have been given a copy of the post-op instructions.

Initials_____

Principal Risks and Complications: I understand that some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in 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 surgery procedure, bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, and transient (on rarest of occasions permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. 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 2nd procedure if the initial results are not satisfactory, or if a post-operative infection or complication necessitates removing the bone graft. 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 any prior drug reaction, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and my taking all medications prescribed are important to the success of the procedure.

Alternatives to suggested Treatment: I understand that alternatives to sinus augmentation surgery may include: 1) no treatment, 2) dental bridgework (if there are good adjacent teeth for supporting a fixed bridge), 3) removable partial dentures, and 4) no teeth replacement.

Necessary Follow-up Care and Self-Care: 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 understand smoking and smokeless tobacco may adversely affect healing and may cause pain and/or a poor result, especially if used during the 1st month. If you must smoke, keep it under 5 cigarettes a day and only smoke the 1st half of the cigarette and discard it. Do not smoke the day before, the day of and 3 days after the sinus augmentation surgery. No smokeless tobacco.

I should not use a water-pik for 1 month.

Initials_____

I have told Dr. Sebastian about any pertinent medical conditions I have, known allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives)), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Sebastian about any present or prior head and neck radiation therapy.

I have told Dr. Sebastian about any present or prior use of bisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Sebastian can evaluate and report on the outcome of surgery to my dentist. It may be necessary to remove both non-resorbable sutures and non-resorbable membranes used in the sinus augmentation bone regeneration surgery.

I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr Sebastian for post-operative check-ups as needed.
3. Not smoke or use smokeless tobacco as noted above.
4. Avoid water-piks for at least one month.
5. Have any non-dissolvable sutures (stitches) and membranes removed.
6. Get the tooth/teeth replaced as recommended.

No Warranty or Guarantee: While in most cases bone regenerative surgery heals quickly and without any problems, complications such as those listed previously, can happen 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 the advancement of dentistry, in written or internet publications or sites, and 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: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during or after its completion with my insurance carriers, 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.

Initials_____

PRF: I may have several vials of my own blood drawn to make Platelet Rich Fibrin (PRF). PRF is a component of my own blood. Blood contains platelets, which contain growth factors that help stimulate soft tissue healing. My blood will be placed in a centrifuge to concentrate the platelets. This will activate the platelets.

Procedure(s) to be performed:

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Patient Consent

I have been informed of the nature of the sinus augmentation oral surgery, the procedure to be utilized, the risks and benefits of this surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Sebastian and his staff members. After thorough deliberation, I hereby consent to the performance of the oral surgery as presented to me during consultation as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Sebastian.

_____ _____

Date [Printed name of patient, parent or guardian]

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[Signature of patient, parent or guardian]

_____ _____

Date [Printed name of witness]

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[Signature of witness]