

## **CONSENT FOR THE USE OF BONE AUGMENTATION PROCEDURES**

**Diagnosis.** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have insufficient bone height and/or width and as such the lack of bone support will not allow dental implants to be positioned in the correct position to be restored in the future. It may also not allow dental implants to be placed at all. Bone augmentation may also be used for edentulous areas to improve aesthetic and functional results of prosthetic work such as fixed or removable partial dentures.

**Recommended Treatment.** In order to treat this condition, my periodontist has recommended that my treatment include bone augmentation surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may also be used.

During this procedure, my gum will be opened to permit access to bone from different parts of my jaw (back of lower jaw or area of chin for example) to be harvested for use in other parts of my mouth.

Donor bone (allograft from a tissue bank) may be used as well to supplement the bone harvested from my body. Synthetic materials (alloplasts) may also be used as deemed necessary. Processed cow/pig bone (xenograft) may be used to supplement the bone harvested or already present in the recipient site. Membranes (barriers) may be used with or without graft material. These barriers are typically of bovine (cow) or porcine (pig) derivation. My gum will be sutured back into position over the above materials, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include termination of the procedure prior to completion of all of the surgery originally outlined.

**Expected Benefits.** The purpose of bone augmentation surgery is to provide additional bone in areas of my jaw or sinus to be able to support dental implants.

**Principal Risks and Complications.** I understand that some patients do not respond successfully to bone augmentation procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases, the involved teeth/implant may ultimately be lost.

I understand that complications may result from the periodontal surgery involving bone augmentation procedures, the use of materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasm, transient, but on occasion permanently increased tooth looseness, sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth/implant and greater spaces between some teeth/implant, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, adverse impact on speech, allergic reaction and accidental swallowing of foreign matter.

In the event that donated tissue is used for the graft, the tissue should have been tested for hepatitis, syphilis, and other infectious disease. Nevertheless, there is a remote possibility that tests will not determine the presence of diseases in a particular donor tissue. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my tissue will heal. I understand that there may be a need for a second procedure if the initial surgery is not entirely successful. In addition, the success of bone augmentation procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of the teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care as recommended by my periodontist and taking all medications as prescribed is important to the ultimate success of the procedure.

***Alternatives to Suggested Treatment.*** Alternatives to periodontal surgery with bone augmentation surgery include:

- 1) no treatment- which may result in the inability to proceed with dental implant therapy,
- 2) fixed or removable partial dentures, or no treatment are alternatives that may be investigated.

***Necessary Follow-up Care and Self-Care.*** I understand that it is important for me to continue to see my regular dentist. Following the surgery it is important not to wear a prosthesis such as an interim or definitive partial denture for approximately two weeks or until expressly allowed by my periodontist. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I recognize that natural teeth and their artificial replacements (implants) should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that the periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by my periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances. It is important to note that medications typically taken for osteoporosis, certain cancers as well as other disorders (bisphosphonates or other types of medication) such as Fosamax or Prolia may NOT allow proper healing and may cause additional damage to my bone and teeth.

***No Warranty or Guarantee.*** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, treatment should provide benefit in improving the amount of bone volume present to provide additional support to teeth or implants or allow placement of implants. Due to individual patient differences, however, a periodontist cannot predict the absolute certainty of success. There exists the risk of failure, partial success, additional treatment, or worsening of my present condition.

***Publication of Records.*** I authorize photos, slide, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

***Governing Law.*** I agree that the relationship between me and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

***Jurisdiction.*** I acknowledge that the treatment /service is to be performed in the province of Ontario, and agree that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment.

**PATIENT CONSENT**

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

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT**

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed Name of Patient,  
Parent or Guardian)

\_\_\_\_\_  
(Signature of Patient, Parent  
or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed Name of Witness)

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(Signature of Witness)