CONSENT FOR SINUS AUGMENTATION

I hereby authorize and request Dr. Sharma to perform corrective surgery on my jaw. The operation is planned to implant a bone substitute material, donor bone (allograft from a tissue bank) or freeze dried de/mineralized bone and/or synthetic materials (alloplasts) such as hydroxyapatite, and/or animal bone (xenograft from a tissue bank) into the floor of the sinus in the hope that new bone will be incorporated into the material so that an implant(s) might be placed to supplement the bone harvested from my body. Membranes (barriers) may be used with or without graft material. These barriers are typically of bovine (cow) or porcine (pig) origin. A second procedure may be needed to place the implant(s). It is hoped that the implants will become stable and act as anchors for fixed or fixed detachable crowns, bridges or dentures.

Dr. Sharma has explained that if the new bone does not incorporate into the synthetic material that alternative prosthetic measures will have to be considered.

Dr. Sharma has explained and described the procedure to my satisfaction. It is understood that although good results are expected no guarantee that it will last for any specific period of time can be or has been given.

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. It is important to note that medications typically taken for osteoporosis, certain cancers as well as other disorders (bisphosphonates) such as Fosamax may NOT allow proper healing and may cause additional damage to my bone and teeth.

I understand that complications may result from the periodontal surgery involving bone augmentation procedures, the use of materials, drugs, or anesthetics. I have been informed and understand that occasionally there are complications of surgery, drugs and anesthesia, including, but not limited to:

1. Pain, swelling and postoperative discoloration of face, neck and mouth.
2. Altered sensation including numbness, tingling, or burning of the lip(s), chin, gums, teeth check and palate, which may be transient, but may be permanent.
3. Infection of the bone that might require further treatment, including hospitalization and surgery.
4. Malunion, delayed union or non-union of the synthetic bone replacement material to normal bone, or lack of adequate bone growth into the synthetic material.
5. Bleeding which may require blood transfusions or other extraordinary means to control.
6. Limitation of jaw function.
7. Stiffness of facial and jaw muscles.
8. Injury to the teeth.
9. Referred pain to the ear, neck and head.
10. Postoperative complications involving the sinuses, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the upper cheek and eyes.
11. Postoperative unfavorable reactions to drugs, such as nausea, vomiting and allergy.
12. Possible loss of teeth and bone segments.
13. Possible bruising and/or discoloration of the face, usually of a temporary nature.
14. Shrinkage of the gum upon healing resulting in elongation of some teeth/implant and greater spaces between some teeth/implant.
15. Cracking or bruising of the corners of the mouth.
16. Restricted ability to open the mouth for several days or weeks.
17. Adverse impact on speech,
18. 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.

I further understand that I am to refrain from the use of alcohol or non-prescribed drugs during the treatment period. If sedation is used I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

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 <u>not</u> 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 <u>NOT</u> 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 allowing dental implant placement. 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 sinus 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)