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DISCUSSION & INFORMED CONSENT for BONE GRAFT
Rev 07/2019

FACTS FOR CONSIDERATION
I have been informed of the need for bone grafting/site preservation. Bone grafting assists with the growth of bone where the tooth root was previously located and to help prevent bone loss during the healing period (a significant amount of bone resorption occurs immediately after the tooth is extracted). The primary purpose of a tooth socket graft is to allow the dental implant placement either at the same time as the surgery or three to six months later. Another purpose of this surgery may be to assist with rebuilding a resorbed ridge for better aesthetics and function where a replacement tooth will be located as part of placing a dental bridge.

I have been informed that I may need a ridge augmentation procedure. A ridge augmentation procedure is often needed prior to implant placement because there is not adequate ridge width for an implant to be placed. Often times the existing ridge width atrophies (narrows) if a significant period of time has passed after extraction. In order to regain ridge width to have adequate bone such that an implant can be surrounded on all sides by bone, a ridge augmentation procedure is required. Another purpose of this surgery may be to assist with rebuilding a resorbed (shrunken) ridge for better aesthetics and function where a replacement tooth will be located as part of placing a dental bridge.

I have been advised that bone grafting may be performed in areas of my mouth. It has also been explained to me that this is a procedure that may involve using commercially made bone graft from another human or animal bone source. The graft material may be used in a block form over a large area or in particulate form for smaller areas. I acknowledge that I have had an opportunity to discuss these options, and my choice, with my dentist before consenting to this treatment, procedure or surgery.

BANKED BONE (FREEZE-DRIED, LYOPHILIZED, DEMINERALIZED, XENOGRAFTS) OR BONE SUBSTITUTES
On occasion, additional donated, processed, or artificial bone substitutes are used to supplement the patient's bone, or to spare an extensive graft harvesting procedure. If used, such materials may have separate risks including, but not limited to:

- Rejection of the donated or artificial graft material.
- The remote chance of viral or bacterial disease transmission from processed bone.

I understand that in my grafting procedure, we are using the freeze-dried allograft bone.

I acknowledge and state that I do not have any objection to the source or origin of the bone graft material whether it be human, animal or artificial. In our office, we used freeze-dried allograft bone.

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BENEFITS OF BONE GRAFTING AND/OR REGENERATIVE SURGERY, NOT LIMITED TO THE FOLLOWING:
The goal of bone grafting is to assist or help "grow" bone back or to possibly allow for dental implant placement either at the same time as this surgery or a later date. Additionally, the purpose of this surgery may be to help build a restorable jaw ridge (bone) for better aesthetics and function where a replacement (artificial) tooth will go as part of a dental bridge.

RISKS OF BONE GRAFTING AND/OR REGENERATIVE SURGERY, NOT LIMITED TO THE FOLLOWING:
In addition to the risks of the primary surgical procedure that have been explained to me separately, I understand that bone grafting itself involves specific risks.

I understand that with surgery there may be postoperative bleeding, swelling, pain, infection, facial discoloration/bruising, possible migration or loss of bone graft material from the surgery site, injury to neighboring or adjacent teeth and/or temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweet or acidic foods. A temporary or permanent numbing of the surgical areas, oral cavity or face may occur affecting my lips, chin and tongue, possibly affecting my sense of taste. I understand that I may see changes in the appearance of my gums. They may be in a different position on the roots or there may be spaces between the teeth that are larger. I understand that my teeth may appear "longer" and my roots may be exposed. I also understand that there may be a need for a second procedure if the initial surgery is not entirely successful.

I understand that I may receive a topical and/or local anesthetic by injection and/or other medication(s). I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections. In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect my ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. *Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury to the oral cavity or face, resulting in loss of feeling of the chin, lips, gums, and tongue and partial loss of taste can result from an injection.*

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or if other similar concerns arise.

I understand that all medications in this office have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently

taking. They can cause redness and swelling of the tissues, pain, itching, vomiting and/or anaphylactic shock. I attest that to my knowledge, I have given an accurate report of my physical and mental health history. I have also report any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I understand that smoking tobacco and marijuana and/or chewing tobacco and/or alcohol intake may affect my ability to have normal gum and/or bone healing and may limit the potential for a successful outcome of my surgery. Smoking may adversely affect the extraction site healing and may cause "dry socket" (an infection of the bone of the socket walls). Smokers are at higher risk for "dry socket" and have more dry sockets than non-smokers. I agree to follow my dentist's instructions related to daily care of my mouth, teeth and gums.

I understand if I have taken or take medication for osteoporosis or cancer treatment that is a bisphosphate (such as but not limited to: Zometa, Aredia, Fosamax, Boniva, Acetonel), on rare occasions osteonecrosis (lack of blood to the jaw bone cells cause these cells to die) of the jaw may occur after an extraction and/or surgery; therefore, it is critical that I tell my dentist of all medications and vitamins I am currently taking, which I have done.

ALTERNATIVES TO SUGGESTED TREATMENT:
I understand that alternatives to bone graft include no treatment.

FOR ALL PATIENTS
I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The dentist will explain all changes.

I have been given the opportunity to ask questions about Bone Graft and believe that I have sufficient information to give my consent as noted below.

CONSENT
I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

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I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

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