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CONSENT FOR MAXILLARY SINUS AUGMENTATION (SINUS LIFT)

Patient Name: _____

Doctor Name: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information.

Condition

My doctor has explained the nature of my condition to me: There is not enough bone to place a dental implant(s) securely.

Procedure – Augmentation grafting of the maxillary sinus

My physician has proposed the following procedure to treat or diagnose my condition: Maxillary Sinus Augmentation. This means grafting of the maxillary sinus with the use of a bone particulate. This bone will be added into the floor of the sinus through an intra-oral surgical procedure and allowed to heal for 4-10 months.

Alternatives

My physician has explained the following medically acceptable alternatives to be: A bridge, a partial denture, full denture, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, I understand that I will not be a candidate for implants.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Complications/Risks

The doctor will give his best professional care toward accomplishment of the desired results. I understand that inherent to any procedure, and because of individual variation, certain risks are involved with treatment. These include but are not limited to:

A. Pain, swelling, or bruising which may extend up to the eye causing a black eye
B. Bleeding which may be prolonged
C. Infection requiring additional treatment or removal of graft material
D. Injury to nerve underlying the teeth resulting in numbness or tingling of the lip, cheek, gums, and tongue. This may persist for a short time or even in remote chance, be permanent
E. Particles of bone graft material noted in mouth or nose
F. Stretching of the corners of the mouth with resulting cracking and bruising
G. Restricted mouth opening and possible joint (TMJ) problems
H. Injury to adjacent teeth and fillings
I. Hot or cold sensitivity
J. Tooth mobility
K. Root canal therapy
L. Speech changes
M. Exposure of existing crown margins
N. Gum recession – longer looking teeth

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, which can be increased by the effect of alcohol or other drugs. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use any sedatives, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat if not as advised by my doctor. I will arrange for someone to drive me to and from the office after I have received sedation, and to have someone watch me closely afterwards.

Necessary Follow-up Care and Self-Care.

I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing. I will not drink alcohol or take non-prescribed drugs during the treatment period. If oral sedation or pain medications are used, I will not to operate a motor vehicle or hazardous device during the course of taking these medications. I agree to cooperate completely with the doctor's recommendations while under his care. If I don't fulfill my responsibility, my results could be affected. Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

Photography

X_____I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Understanding

X_____I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

X_____ The procedure I chose to treat this condition is understood by me to be bone grafting into the maxillary sinus region. This bone graft could include materials of human and/or animal origin. I understand that the purpose of this procedure is to augment the volume of bone in my maxillary sinus in order to provide enough support for the placement of dental implants in the future.

X_____I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have been advised of all alternative treatments.

X_____I also understand that during the course of the procedure, unforeseen conditions may arise that necessitates an extension or alteration of the planned procedure contained herein. I therefore authorize and request that the doctor and his associates or assistants under his direction perform such procedure as found necessary and administer such treatments as required in their professional judgment.

X_____I have had the opportunity to discuss with the doctor the planned surgical procedure, sinus augmentation, and my postoperative responsibilities. I understand that following the procedure during the healing process I should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two

weeks.

X_____I have been informed about all post-operative medications and side affects from these medications. I understand that some medications will benefit me and the outcome of this procedure. Therefore, I will take all recommended medications accordingly.

X_____I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there exists a risk of failure or necessity of additional treatment despite appropriate care.

X_____I understand that the fee I am to be charged has been disclosed to me and is satisfactory to me. I understand that I am responsible, with or without the aid of my dental insurance, for all payment for any procedures completed today

I CERTIFY THAT I HAVE FULLY READ AND UNDERSTAND THIS CONSENT AND THAT I AUTHORIZE FOR THE PROPOSED TREATMENT DESCRIBED. I ACCEPT THE RISKS IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULT OF THE TREATMENT. ALL QUESTIONS AND EXPLANATIONS WERE TO MY SATISFACTION. I HAVE BEEN INFORMED THAT REGARDLESS OF THE EFFORT OF MY PERIODONTIST TO INSURE SATISFACTION, THE RESULTS MAY PRODUCE A LESS THAN DESIRED RESULT.

_____ _____

Patient's Name (Printed) Date

_____

Patient's or Guardian's Signature

If not the patient, what is your relationship to the patient?

_____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

_____ _____

Doctor's Signature Date