Perio & Implant at Washington Metro

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SINUS ELEVATION/GRAFT PATIENT INFORMATION AND COSENT FORM

1. I have been informed and I understand the purpose and the nature of the sinus elevation / graft and dental implant surgery procedures. I understand sinus elevation procedure is necessary to accomplish the placement of the implant under the gum in the bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire dental implants to help secure the replacements for my missing teeth. My maxillary sinus will have to be reduced in volume and a bone graft will be placed to facilitate implant placement in my upper jaw. The bone graft may be composed of sterilized bone from human donors, and / or animals (generally cow bone) and / or synthetic mineral graft materials

3. I have further informed of the possible risks involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, sinus infection and skin discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration of this numbness may not be determinable and may be irreversible. Also possible are damage to blood vessels that cause intra-operative or post-operative bleeding , injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications, or other adverse consequences. In case any of these complications happens, my doctor will treat the complications or refer me to other physician or specialist to treat the complications. I will be fully cooperative of this treatment of complications.

4. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the sinus graft and / or implant.

5. It has been explained that in some instances sinus graft and / or implants can fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment or surgery can be made. I understand that in case of failure of the sinus elevation or implants, no fees which I have paid will be refunded to me.
6. I understand that smoking, alcohol and / or drugs may affect gum and bone healing and may interfere with the success of the implants. I agree to follow my doctor's home care instructions and not to wear any removable plates (dentures) during the healing phase unless my doctor advises me otherwise. I agree to report to my doctor for regular examinations and follow-up care as instructed.

7. I agree to the type of anesthesia, depending on the choice of the doctor. I agree that if I am given medications to relax me, I will not operate a motor vehicle or hazardous device or undertake legal transactions for at least 24 hours or more until totally recovered from the effects of the anesthesia or drugs given for my care.

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8. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetic, pollens, dust, blood or body disease, gum or skin reactions, abnormal bleeding tendencies and any other conditions related to my health.

9. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

10. I request and authorize medical/dental services for me, including sinus elevation and implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, material, or core, if it is felt this is for my best interest.

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Signature of the Dentist (Date) **Signature of the Patient (Date)**

_____ _____

Witness (Date) **Relationship to Patient**