General & Implant Dentistry

INFORMED CONSENT FOR SINUS LIFT PROCEDURE

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Patient's Name:

Date:

The following has been explained to me in general terms and I understand that:

(1) **The diagnosis requiring this procedure is loss of a tooth or teeth inadequate prosthetic support with resulting bone loss.**

(2) **The nature of the procedure is lateral infracture of the maxillary sinus wall, elevation of the sinus membrane, and subantral augmentation with bone graft. The bone graft material to be utilized is either bank bone obtained from human donors, a synthetic bone grafting material, genetically reengineered bovine bone or bone obtained from the patient.**

(3) **The purpose of the procedure is to gain additional bone for insertion of an endosseous implant which will serve as additional prosthetic support.**

(4) **The likelihood of success of the above procedure is:**
() Good   () fair   () poor

(5) **Practical alternatives to this procedure are not doing a bone graft, or removable prosthesis.**

(6) **If I choose not to have the above procedure, my prognosis (future medical condition) is additional bone loss, inadequate occlusal support, and difficulty properly masticating food.**

(7) **Material risks of this procedure:**

Procedure will be done with Nitrous/Oxide sedation and local anesthetic. If procedure was being performed under general anesthesia: (I.V. sedation) there may be material risks of: INFECTION, LOSS OF FUNCTION OR OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:

- **(a) Post-operative discomfort and swelling that may necessitate several days of home recuperation**
- **(b) Injury to adjacent teeth and fillings**
- **(c) Stretching of the corners of the mouth with resultant cracking and bruising**
- **(d) Restricted mouth opening for several days or weeks**
- **(e) Infection of the bone graft involving the maxillary sinus. If an infection takes place it may require taking post-operative antibiotics, as well as the removal of the bone grafting material.**
- **(f) The bone graft may not heal properly and a second surgical procedure may be required to remove the bone grafting material. Additional surgery may be required to eliminate any infection to the sinus.**
- **(g) Postoperative infections may occur, requiring additional treatment.**

I understand that the medical/dental personnel and others will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been explained.

I understand that the practice of dentistry and medicine are not exact sciences and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described, it may be necessary or appropriate to perform additional procedures which may not be known to be needed at the time this consent is given. I authorize the persons described herein to make decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as may be deemed necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and other treatment or courses of treatment relating to the diagnoses or procedures described herein.

I also consent that any tissues or specimens removed from my body in the course of any procedures may be tested for scientific purposes and then disposed of within the discretion of the physician, facility, or other health care provider.

I understand that certain medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which may be increased by the use of alcohol or other drugs. Thus I have been advised not to drive or operate hazardous equipment or work while taking medications and/or drugs until I have fully recovered from the effects. I understand and agree that if I have been sedated or given general anesthesia, I will not operate any vehicle or hazardous device for 24 hours after my release from surgery. I agree not to drive myself home after surgery and will have a responsible adult drive me home after being discharged from surgery.

Female patients: Research indicates that the reliability of oral contraceptives can be significantly diminished with the use of some antibiotics and other medications which may be used during the course of treatment. Alternative or additional forms of birth control should be used until the course of antibiotics or prescribed medication is completed.

I understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible dentist/surgeon, all medical-dental personnel under direct supervision and control of the responsible dentist/surgeon and for any medical/dental personnel otherwise involved in the course of treatment.

I understand that smoking, alcohol and sugar intake may adversely effect healing and increase the likelihood of postoperative infections which may limit the success and prognosis of the surgery and future treatment performed. I agree not to smoke for two weeks prior to surgery and not to smoke following surgery.

I consent to photographs, recordings, and x-rays of the procedure to be performed for the advancement of dentistry.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND IT'S CONSENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ALL QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKKS OR STATEMENTS I DO NOT APPROVE OF WEERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN. I HAVE HAD THE OPPORTUNITY TO EVALUATE THE CREDENTIALS AND EDUCATIONAL BACKGROUND OF TREATING DOCTORS.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Mark Evans, involved in the course of my treatment.

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Person giving consent (patient or legal guardian)

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Relationship to patient if not the patient:

Patient is unable to sign because of:

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Witness

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Doctor