BONE GRAFTING AND BARRIER MEMBRANE CONSENT FORM

For: __________________________

I understand that bone grafting and barrier membrane procedures include inherent risks, including but
not limited to the following:

1. **Pain.** Some discomfort is inherent in any oral surgery procedure. Grafting with materials that do not
   have to be harvested from the body is less painful because they do not require donor site surgery. If
   the necessary bone is taken from the chin or wisdom tooth area, there will be more pain, which can
   be largely controlled with pain medications.

2. **Infection.** No matter how carefully surgical sterility is maintained, it is possible, because of the existing
   nonsterile oral environment, for infections to occur postoperatively. At times, these may be serious in
   nature. Should severe swelling occur, particularly if it is accompanied with fever or malaise, profes-
   sional attention should be sought as soon as possible.

3. **Bleeding, bruising, and swelling.** Some moderate bleeding may last several hours. If bleeding is pro-
   fuse, the office should be contacted as soon as possible. Likewise, some swelling is normal, but if it is
   severe, the office should be notified. Swelling usually starts to subside after about 48 hours. Bruises
   may persist for a week or more.

4. **Loss of part or all of the graft.** Success with bone and membrane grafting is high. Nevertheless, it is
   possible that the graft could fail. A block bone graft taken from somewhere else in the mouth may not
   adhere or could become infected. Despite meticulous surgery, particulate bone graft materials can
   migrate out of the surgical site and be lost. A membrane graft could start to dislodge. If so, the doctor
   should be notified. Patient compliance is essential for success.

5. **Types of graft material.** Some bone graft and membrane materials commonly used are derived from
   human or other mammalian sources. These grafts are thoroughly purified to be free of contaminants.
   Signing this consent form signifies my approval for the doctor to use materials according to his or her
   knowledge and clinical judgment of my situation.

6. **Injury to nerves.** A possible consequence of the surgical procedures or anesthetic administration is
   injury causing numbness of the lips and tongue as well as any tissues of the mouth, cheeks, and/or
   face. This numbness may be of a temporary nature, lasting a few days, weeks, or months, or could
   possibly be permanent.

7. **Sinus involvement.** In some cases, the root tips of upper teeth lie in close proximity to the maxillary
   sinus. Occasionally, with extractions and/or grafting near the sinus, the sinus can become involved. If
   this happens, special medications will be necessary. Should sinus penetration occur, it may be neces-
   sary to later have the sinus surgically closed.

I understand that it is my responsibility to seek attention should any undue circumstances occur postop-
eratively and that I should diligently follow any preoperative and postoperative instructions.

**Informed Consent**

As a patient, I have been given the opportunity to ask questions regarding the nature and purpose of
surgical treatment and have received answers to my satisfaction. I voluntarily assume any and all pos-
sible risks, including the risk of harm, if any, that may be associated with any phase of this treatment in
hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises
have been made to me concerning my recovery and results of the treatment to be rendered to me. The fees for this service have been explained to me and are satisfactory. I authorize photographs, slides, x-rays, or any other visual records of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission. By signing this form, I am freely giving my consent to allow and authorize Dr and his or her associates to render any treatments necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient name

Signature of patient

Date