



REQUEST AND CONSENT FOR TREATMENT SINUS LIFT PROCEDURE WITH BONE GRAFTING AND POSSIBLE IMPLANT PLACEMENT

For _____

I authorize and request Dr Link to perform surgery on my upper jaw (maxilla).

I understand that surgery will be performed to place a bone graft material into the floor of the sinus to build adequate bone height for the placement of implants. The bone graft will consist of a bone substitute material (hydroxyapatite), tissue bank bone, or a combination of both. In approximately 5 to 6 months, after the graft has partially healed, a second procedure will be done to place the implant(s) in the upper jaw and the grafted material. In some cases, it is possible to place the implants and graft during the same procedure. It is expected that the implants will become stable and act as anchors for fixed or fixed-detachable dentures.

Dr Link has explained and described the procedure to my satisfaction, including the fact that if the new bone does not incorporate into the bone graft material, alternative prosthetic measures will have to be considered.

I have been informed that the likelihood for success of the suggested treatment plan is good; however, there are risks involved. The bone graft material has produced good results when placed on top of the upper or lower jaw ridge. However, there are insufficient long-term studies to evaluate placement of the material on the sinus floor. This bone graft replacement material has previously been shown to be free from rejection or infection; however, there is no guarantee that my graft will not become infected or be rejected. There have been some cases of failure of the graft to incorporate into new bone or to sustain implants. Rarely, implants have failed and require removal; occasionally, the area can be regrafted and implants reinserted.

It is understood that although good results are expected, they cannot be and are not implied, guaranteed, or warrantable. There is also no guarantee against unsatisfactory or failed results

I have been informed and understand that occasionally there are complications of surgery, drugs, and anesthesia, including but not limited to:

1. Pain, swelling, and postoperative discoloration of the face, neck and mouth.
2. Numbness and tingling of the upper lip, teeth, gums, cheek, and palate, which may be temporary or, rarely, permanent.
3. Infection of the bone that might require further treatment, including hospitalization and surgery.
4. Mal-, delayed, or nonunion of the bone graft replacement material to the existing bone.
5. Lack of adequate bone growth into the bone graft replacement material.
6. Bleeding that may require extraordinary hemorrhage-control measures.
7. Limitation of jaw function.
8. Stiffness of facial and jaw muscles.
9. Injury to the teeth.
10. Referred pain to the ear, neck, and head.
11. Postoperative complications involving the sinuses, nose, nasal cavity, sense of smell, infraorbital, regions, and altered sensations of the cheek and eyes.
12. Postoperative unfavorable reactions to drugs, such as nausea, vomiting, and allergy.
13. Possible loss of teeth and bone segments.

Initial

I understand that I am not to use alcohol or nonprescription drugs during the treatment period. Dr. Link has informed me that smoking is particularly detrimental to the success of this operation; therefore, I have been asked to abstain from smoking.

I understand that Dr Link will give his best professional care toward the accomplishment of the desired results. I understand that I can ask for full recital of all possible risks attendant to phases of my care. I further understand that I am free to withdraw from treatment at any time.

I give permission for persons other than the doctors involved in my care and treatment to observe this operation. 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. I understand this consent form and request Dr Link to perform the surgery discussed.

Signature of patient _____ Date _____

Signature of doctor or witness. _____ Date _____