BONE GRAFT SURGERY

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1. I have been informed and afforded the time to fully understand the purpose and the nature of the bone graft surgery procedure. I understand what is necessary to accomplish the placement of the bone graft under the gum on/or 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 a bone graft to help secure the replaced missing teeth.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are thrombophlebitis (inflammation of the vein), injury to teeth, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

4. I understand that if nothing is done any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done an inability to place a bone graft or implants at a later date due to changes in oral or medical conditions could exist.

5. My doctor has explained that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft. It has been explained that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.

6. It has been explained that in some instances bone grafts fail (mal-union, delayed union, or non-union of the donor bone graft to the recipient bone site) and must be removed. It also has been explained to me lack of adequate bone growth into the bone graft replacement material could result in failure. 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 the results of treatment or surgery can be made. I am aware that there is a risk that the bone graft surgery may fail, which might require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. If the bone graft surgery fails I understand that alternative prosthetic measures may have to be considered.

7. I understand that excessive smoking, alcohol, or blood sugar may effect gum healing and may limit the success of the bone graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the following procedures:

□ Autogenous graft – Which transplants bone from one region to another.

Donor Site	□ Chin (mental symphysis) □ Edentulous area □ Maxillary tuberosity □ Ascending ramus □ Iliac crest □ Tibia □ Other_____	Recipient Site	□ Upper arch □ Lower arch □ Edentulous area □ Sinus

□ Allograft- Which transplants bone from one individual to a genetically non-identical individual of the same species (cadaver bone). All allografts are processed from donors found to be negative by FDA tests for HBsAg, ani-HBc, anti-HC, STS, antiHIV1/2, and anti-HTLV-I. Although efforts are made to ensure quality, most tissue banks make no claims concerning the biological or biomechanical properties of provided allograft. All allografts have been collected, processed, and distributed for use in accordance with the Standards of the American Association of Tissue Banks.

PATIENT TREATMENT REQUEST

Please Illustrate and answer ALL questions below pertaining to the treatment as recommended.

I hereby request the following doctor to render treatment as I have illustrated and answered below:

_____
Doctor's Name

1. **I hereby request treatment for the purpose of:**
   _____
   _____

2. **I understand should I not have treatment, the following may occur:**
   □ **MAXILLA:** _____
   □ **MANDIBLE:** _____

3. **I understand the following treatments may be utilized as an alternative for my condition:**
   □ **MAXILLA:** _____
   □ **MANDIBLE:** _____

4. **I understand the treatment for my dental condition will be by the following procedure:**
   □ **MAXILLA:** _____
   □ **MANDIBLE:** _____

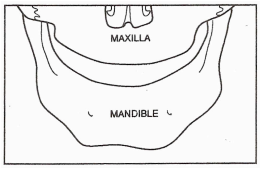
5. **I understand the proposed treatment has the following benefits over the alternative procedures:**
   □ **MAXILLA:** _____
   □ **MANDIBLE:** _____

6. **I understand the proposed results of the treatment are as follows:**
   □ **MAXILLA:** _____
   □ **MANDIBLE:** _____

7. **I understand, as in the case of ANY surgical treatment, there is a risk factor. The risks have been explained to my satisfaction and they are as follows:**
   _____
   _____
   _____

Please illustrate and describe the corresponding recommended treatment:

_____
_____
_____
_____
_____
_____
_____
_____



Patient_____ **Date**_____

Witness_____ **Date**_____

Dentist_____ **Date**_____