**Consent for Bone Graft**

# Consent for Bone Graft

Patient First Name: Patient Last Name: DOB: BONE GRAFT Tooth #:

The purpose of this document is to provide written information regarding the risks, benefits and alternatives of the procedures named above. This material serves as a supplement to the discussion you have with the doctor. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask the doctor prior to signing the consent form.

## THE PROCEDURE

Bone graft surgery is intended to replace lost bone for reconstructive or esthetic purposes. A bone graft can be done in conjunction with an extraction, and/or at the time of implant placement. During surgery, you will be given a local anesthetic, which is an injection of drugs that cause numbness in the location of this dental procedure. A lack of adequate bone growth into the bone graft replacement material may also result in failure of the graft. It is possible that reconstructive surgery may be necessary associated with and/or following removal of the graft. I understand that alternative prosthetic procedures may be required should the bone graft fail Follow-up Treatment: It is absolutely necessary following the placement of bone grafts to schedule all necessary post-operative visits as recommended by the doctor.

## RISKS

I acknowledge that alternatives to these procedures have been explained to me. I understand that risks of having the bone graft procedure include, but are not limited to: * Bleeding, Bruising and/or swelling at the treatment site. * Discomfort from incomplete numbing of the area. * Discomfort or pain from the injection site. * Incomplete relief of pain. * The procedure may need to be repeated. * Bone infection (osteomyelitis). * Problems with the bone healing properly. * Trauma to the gums. * Reaction to local anesthesia or other medicines given during or after the procedure. * Wound infection, poor healing or reopening of the incision(s). Blood or clear fluid can also collect at the wound site(s). * Damage to the facial nerve(s). This may change the appearance of your face or make your tongue weak or numb. It may cause partial or complete paralysis of your face. * Damage to the jaw, jaw bone, or nearby structures. This may be discovered during the procedure, or at a later time once healing is complete and swelling has subsided. * Possibility of Failure. In some instances bone grafts fail due to mal-union, delayed union or non-union of the donor bone graft to the recipient bone site and must be removed.

## PRECAUTION

In spite of how carefully surgical sterility is maintained, it is possible that infections may occur postoperatively. Should severe swelling occur, particularly when accompanied with fever, you are to contact our office as soon as possible. It is your responsibility as the patient to inform the doctor of any abnormal side effects that occur after surgery. Any sign of infection may interfere with the success or longevity of the bone graft. For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone, or bone grafts.

## CONTRAINDICATIONS

Excessive smoking, alcohol intake or diabetes: These factors may adversely affect the healing process, limiting the resulting success of the bone graft procedure

## CONSENT

By signing below, I attest to the following: I fully consent to proceed with the bone graft procedure. I understand that there are no guarantees that the proposed treatment will be successful or that I will be completely or partially satisfied. I understand the treatment, the risks of such treatment, any alternatives have been explained to me and the risks of these alternatives, the consequences of doing nothing about my condition, and the fee(s) involved. The doctor has explained this treatment/procedure and what it is for. The doctor has explained to me the alternative treatments that might be done instead, and what would happen if I decline this procedure. The doctor has answered all my questions. I know that I may refuse or change my mind about having this treatment/procedure. I have been offered the opportunity to read the consent form. I hereby give my consent to have this treatment/procedure.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient: