

## Informed Consent for Tooth Socket Bone Grafting

**Patient Name:** \_\_\_\_\_

**Diagnosis:** I have been advised that I may lose significant amounts of jaw bone after my dental extraction in the area where my tooth will be/was removed. The potential loss of jaw bone may not allow the placing of dental implants and/or leaves an unaesthetic/poor functioning area for dental crown(s)/bridgework.

**Recommended Treatment:** In order to help prevent the loss of bone in the area of the removed tooth/teeth, it has been recommended that my treatment include tooth socket bone grafting in the tooth extraction socket left after my tooth/teeth are removed. Antibiotics and other medications may be given. During this procedure, the gums will be opened to permit better access to the bone surrounding the tooth socket, the socket will be prepared and a graft material placed in the prepared tooth socket. Various types of graft materials may be used.

**Bone Graft Materials:** The sources of bone graft materials are from my own bone, synthetic bone substitutes, human donors and/or from bovine (*cow*) or porcine (*pig*) processed in accordance with FDA regulations through FDA approved commercial bone banks/processors. Sometimes sterile, medical grade calcium sulfate (*plaster*) is mixed with the bone. Plaster is inserted and resorbs completely in eight weeks.

A covering may be placed over the bone graft, either a non-resorbable (*needs to be removed*) man-made thin Teflon wafer (*commonly called a Teflon barrier*), synthetic membranes made of PTFE (a derivative of what GorTex® is made from) or a medical grade, resorbable sterile collagen (*commonly called collagen barrier*) in a wafer from derived from either bovine (*cow*) or porcine (*pig*). The purpose of the barrier is to keep the bone graft material in place. Membranes tend to hold the bone graft material in place while it heals. My gum will be sutured (stitched) back into position over the above mentioned materials.

**Expected Benefits:** The purpose of tooth socket bone grafting is to assist with the growth of bone where the tooth root used to be and to help prevent bone loss during the healing period. The primary purpose of a tooth socket graft is to allow dental implant placement either at the same time as the surgery or three to six months later. Another purpose of this surgery may be to help build a resorbed ridge for better esthetics and function where a fake tooth will go as part of doing a dental bridge.

**Principle Risks and Complications:** I understand some patients do not respond successfully to tooth socket bone grafting procedures. The procedure may not be successful in preserving function or allowing a dental implant to be place. Because each patient's condition is unique, long term success may not occur.

Complications that may result from surgery could involve the bone regenerative materials, drugs, and anesthetics. These complications include, but are not limited to, post-operative infection, bleeding, swelling, scarring, pain, bruising, numbness of the jaw, lip tongue, chin or gum, jaw joint injuries or muscle spasm, cracking or bruising of the corners of the mouth,

restricted ability to open mouth for several days or weeks, impact of speech, allergic reactions, accidental swallowing of foreign matter, transient (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. The exact duration of any complication cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. There may be a need for a more extensive bone regenerative surgery if the initial tooth socket graft results are not satisfactory. In addition, the success of oral surgery and dental implant procedures can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my dentist any prior drug reaction, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I fully understand that my diligence in providing the personal daily recommended by my dentist and taking all medications prescribed are important to the success of the procedure.

**Alternatives to Suggested Treatment:** I understand that alternatives to tooth socket bone grafting are as follows:

1. No bone grafting
2. Fix bridge with/without bone grafting
3. Denture with/without bone grafting
4. Dental implant with/without bone grafting

**Necessary Follow-Up Care and Self Care:** I fully understand and acknowledge it is important for me to continue to see my dentist for routine dental care and to get the missing tooth/teeth replaced as recommended.

I fully understand and acknowledge smoking and smokeless tobacco may adversely affect healing and may cause pain and/or poor results.

I have told the dentist about any pertinent medical condition(s) I have, known allergies, any medications I am taking including over the counter medications such as aspirin, nutritional supplements and/or herbs.

I have told the dentist about any present or prior head and/or neck radiation therapy I have undergone. I have told the dentist about any present or prior use of Bisphosphonate medications. That may lead to osteoradionecrosis of the jaw bone.

I fully understand I need to come back for several post-operative visits so my healing may be monitored and so the dentist can evaluate and report on the outcome of the surgery to any other doctors involved with my care. It may be necessary to remove both non-resorbable membranes and non-resorbable sutures used in the bone regeneration surgery.

I acknowledge that it is important to:

1. Abide by the specific prescriptions and instruction given
2. See the dentist for scheduled post-operative visits as needed
3. Have any non-dissolvable sutures and/or membranes removed
4. Get the tooth/teeth replaced as recommended

**No Warranty or Guarantee:** I acknowledge no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases bone regenerative surgery heals quickly and without incident. Due to individual patient differences; however, there can never be a certainty of success. There is a risk of failure, and complications such as those listed above, despite the best of care.

**Publication of Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

**Communication with my Insurance Company, My Dentist or other Dental/Medical Providers involved with my care:** I authorize sending correspondence, reports, chart notes, completion with my insurance carriers, the dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

**Females Only:** Antibiotics may interfere with effectiveness of oral contraceptives (*birth control pills*).

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent the performance of the oral surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist. I have read and understand this document before I signed it.

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Signature of patient, parent or guardian	Printed Name	Date
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Signature of Dentist	Printed Name	Date
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Signature of Witness	Printed Name	Date
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