Consent Form: Maxillary Sinus Bone Augmentation

The purpose of the procedure is building a bone in the maxillary sinus for the placement of dental implants, either at the same time of performing maxillary sinus bone augmentation or at a later stage, in an additional surgical procedure. It was explained to me that permanent oral rehabilitation using dental implants is feasible only after the integration of the dental implants.

Name of patient: _____

Last Name First Name Father's Name ID. No.

I declare and confirm that I received a detailed oral information from:

Dr. _____

Last name First Name

on bone graft/bone substitutes with/without dental implants in the upper/lower jaw (Hereinafter: The "Principal Treatment").

I was informed of the necessary treatment for bone grafting and placement of the dental implants, including the expected results, as well as possible alternative treatments, subject to my dental condition. The alternative treatments were considered by me before choosing this treatment. **It was explained to me that during the surgical procedure, it might become apparent that the bone graft cannot be performed.**

The volume of bone remaining available after bone grafting is unpredictable and therefore, it may be necessary to repeat the bone grafting procedure to allow for placement of the dental implants.

I was informed as well of the importance of quitting smoking before and after the treatment, of treating gum disease and of controlling diabetes. It was made clear to me that smoking, untreated gum disease and diabetes significantly increase the risk of bone graft failure. It was further made clear to me that the combination of surgical treatment and bisphosphonate medications, whether such medications are being taken now or had been taken in the past (medications for the treatment of osteoporosis and/or of bone diseases) increase the risk of chronic inflammation up to necrosis of the jaw bones.

I was informed of the possible side effects of the Principal Treatment, including considerable swelling, hemorrhages in the cheek and neck area and temporary limitation in mouth opening; significant swelling around the eye at the side of the surgery and bleeding from the nostril at the side of the surgery.

I was also informed of the risks and complications related to the Principal Treatment, including infection, which may require additional surgical procedure and which may require full or partial removal of the bone graft and/or of the dental implants; possible development of a fistula between the oral cavity and the sinus cavity which will require further surgical treatment; considerable hemorrhage which may require additional treatment; possible injury to adjacent dental roots; injury to facial nerves, which means temporary or permanent sensation disorder in the affected site. Furthermore, where osteotomies (an instrument used for cutting or preparing bone) are used, in rare occasions patient may suffer from balance disorders and vertigo.

It was further made clear to me and I understand the importance of continuity of treatment and of the importance of cooperation between the doctor performing the bone augmentation and the doctor performing the prosthetic treatment.

I am also well aware of the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff/doctor, including maintenance of oral hygiene, receiving all necessary operative and prosthetic treatments and attending checkups according to schedule, as required.

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after being informed of the risks and complications of anesthesia including loss of sensation in the lip and/or tongue and/or chin and/or face, hematoma, swelling and temporary limitation in mouth opening.

Should the Principal Treatment be performed under general anesthesia or under intravenous sedation, the anesthetic technique would be explained to me by an anesthesiologist.

_____

Date Patient's Signature

_____

Name of Guardian (Relationship) Guardian's Signature

(When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained orally to the patient/the patient's guardian all the aforementioned in detail as required and that he/she signed before me, after I was satisfied that he/she fully understood my explanation.

_____ _____ _____

Name of Physician Signature License No.