Consent Form: Bone Augmentation

The purpose of the procedure is building a bone for the placement of dental implants, either on the date of bone augmentation treatment or at a later date. The bone graft material may be taken either from the patient or from an external origin. In the case of bone graft from the patient, the bone graft material may be "harvested" from the oral cavity, the most common sites being the chin or the posterior part of the lower jaw ("the ascending ramus"). In some cases, the bone graft will be fixated using fixation screws or pins, which might be removed in the future.

Name of patient: _____

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

I declare and confirm that I received detailed verbal information from:

Dr. _____

Last name First Name

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

I was informed of the treatment necessary for bone grafting, including the expected results and possible alternative treatments under the circumstances of my condition. I have considered the alternative treatments before choosing this treatment.

It was explained to me that smoking, untreated gum disease and diabetes significantly increase the risk of bone graft failure. I was also informed of the importance of quitting smoking before and after the treatment, of treating gum disease and of controlling diabetes It was further explained to me that the combination of surgical treatment and use of medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma and especially the combination with steroid treatment, smoking and diabetes, increases the risk of chronic inflammation up to necrosis of the jaw bones.

I was informed of the side effects of the Principal Treatment, including considerable swelling, hemorrhages in the cheek and neck area and temporary limitation in mouth opening. I was also informed of the risks and complications related to the Principal Treatment, including infection, which may require additional surgical procedure, injury to adjacent teeth; injury to facial nerves, which means temporary or permanent sensation disorder. Normally, several months after the surgery, dental implants can be placed in an additional surgery. Since the volume of bone remaining for dental implant placement is unpredictable, it may be necessary to repeat the augmentation procedure at that stage.

It was further explained 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 follow-up 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 it be decided to perform the Principal Treatment 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 incompetent, a minor or mentally ill)

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

_____ _____ _____

Name of Physician Signature License No.