



**CONSENT FOR THE USE OF
BONE REGENERATIVE PROCEDURES**

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist (Dr. Lueder) has advised me that I have bone loss around a tooth or several teeth. I understand that this bone loss weakens the support of my teeth and makes my teeth susceptible to localized periodontal infections by separating the gum from the teeth and possibly further destroying the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, the bone defect and periodontal disease can cause me to lose my teeth and may have other adverse consequences to my general health.

Recommended Treatment: In order to treat this condition, Dr. Lueder has recommended that my treatment include bone regenerative surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth. During this procedure, my gum will be opened to permit better access to the gum, roots, and to the eroded bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped. Graft material may be placed in the areas of bone loss around the teeth. Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes may be used with or without the graft material - depending on the type of bone defect present. My gum will be sutured back into position over the above materials, and a periodontal bandage or dressing may be placed. I further understand that unforeseen conditions may call for a modification or change from the anticipated treatment plan. These may included, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of bone regenerative treatment is to reduce infection and inflammation and to restore my gum and bone to the best extent possible. The surgery is intended to help me keep my teeth in the treated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth. The use of bone, bone graft material, or the placement of a membrane is intended to enhance bone and gum healing.

Principal Risks and Complications: I understand that some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases, the involved teeth may ultimately be lost. I understand that complications may result from the periodontal surgery involving bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanently increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum or healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, adverse impact on speech, allergic reactions, and accidental swallowing of foreign matter. In the event that donated tissue is used for the graft, the tissue should have been tested for hepatitis, syphilis, HIV/AIDS and other infectious disease. Nevertheless, there is a remote possibility that tests will not determine the presence of diseases in a particular donor tissue. There has never been a documented case of disease transmission from demineralized freeze-dried cortical bone that may be used in this dental procedure. The exact duration of any complications cannot be determined, and may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not entirely successful. In addition, the success of bone regenerative procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of the teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have

reported to Dr. Lueder my prior drug reactions, allergies, diseases, symptoms, habit, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by Dr. Lueder and his staff and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives To Suggested Treatment: Alternatives to periodontal surgery with bone regenerative surgery include: (1) no treatment – with the expectation of possible advancement of my condition which may result in premature loss of teeth, (2) extraction of a tooth or teeth involved, (3) non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medications, in an attempt to further reduce bacteria and tartar under the gum line – with the expectation that this may not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of teeth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, Dr. Lueder may make recommendations for the replacement of restorations, the replacement of existing restorations or their modification, the joining together of two or more of my teeth (splinting), the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that Dr. Lueder can evaluate and report on the outcome of surgery upon completion of healing. Smoking may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by Dr. Lueder and his staff and (2) to see Dr. Lueder and my dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. In most cases, treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, Dr. Lueder cannot predict the absolute certainty of success. There exists the risk of failure, relapse, and additional treatment, or worsening of my present condition including the possible loss of certain teeth, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays, videos, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and/or reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

PATIENT CONSENT

I have been fully informed of the nature of the bone regenerative treatment, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Lueder. After thorough deliberation, I hereby consent to the performance of the bone regenerative procedure as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Lueder.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____	_____
Date	Printed name and signature of patient, parent or guardian
_____	_____
Date	Printed name and signature of witness
_____	_____
Date	Jacob C. Lueder, DDS, MS Member – Jacob C. Lueder, DDS, MS, PLLC