



**CONSENT FOR SINUS LIFT PROCEDURE  
WITH BONE REPLACEMENT GRAFT**

**Diagnosis:** After a careful oral examination and study of my dental condition, my periodontist (Dr. Lueder) has advised me that my missing upper tooth or teeth may be replaced with an artificial tooth or teeth supported by an implant. However, there is insufficient bone between the oral cavity and the maxillary sinus to allow placement of dental implants and a sinus lift procedure with bone replacement graft is necessary prior to, or during implant placement.

**Recommended Treatment:** In order to treat this condition, Dr. Lueder has recommended that my treatment include a sinus lift procedure with bone replacement graft. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone above my missing upper tooth or teeth and a small portion of bone will be removed to access the floor of the sinus. I understand that surgery will be performed to place a bone graft material onto the floor of the maxillary sinus to build up adequate bone height and volume for the placement of implants. 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 also be used. The soft tissue will be stitched closed and healing will be allowed to proceed for four to eight months. After the graft has partially healed, a second procedure will be done to insert the implants into the upper jaw and grafted material. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase.

I understand, in some circumstances, Dr. Lueder may place the dental implants at the same time as the sinus lift procedure.

I further understand that unforeseen conditions may call for modification or change from the anticipated treatment plan. These may include, but are not limited to, (1) placing the bone replacement graft or dental implants at a later date (2) termination of the procedure prior to completion of all of the surgery originally outlined.

**Expected Benefits:** The purpose of the sinus lift procedure is to add bone height and volume to the floor of the maxillary sinus to allow the placement of dental implants. It is expected that the implants will become stable and act as anchors for fixed or fixed-detachable bridges or dentures in the grafted bone.

**Principal Risks and Complications:** I understand that some patients do not respond successfully to the sinus lift procedure, and in such cases, the bone graft material may need to be removed. The sinus lift procedure may not be successful in providing adequate bone for dental implants. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the sinus lift procedure, drugs, and anesthetics. These complications include, but are not limited to, post-surgical infection or bleeding that might require further treatment including hospitalization and surgery, swelling and pain, discoloration of the face, neck, and mouth, transient but on occasion permanent numbness or tingling of the upper lip, gums, teeth, cheek, or palate, which may be temporary or, rarely, permanent, injuries or associated muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, altered sense of smell, injury to teeth,

bone fracture, sinus penetrations, bloody nose, congestion, or post-nasal drip, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

Dr. Lueder has discussed with me that smoking is particularly harmful to the success of this operation. I have been requested to stop smoking.

Dr. Lueder has explained that if new bone does not incorporate into the bone graft material, alternative tooth replacement measures will have to be considered.

**Alternatives to Suggested Treatment:** Alternative treatments for the sinus lift procedure include no treatment, new removable or fixed appliances, and other procedures – depending on the circumstances.

**Necessary Pre-Surgical, Follow-up, and Self-Care:** I understand that it is important for me to see Dr. Lueder for follow-up care, to follow home care instructions, and to abide by the specific pre- and post-operative prescriptions and instructions given by Dr. Lueder and his staff. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

**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. Due to individual patient differences, Dr. Lueder cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of bone replacement grafts, certain teeth, or implants despite the best 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 sinus lift surgery, the procedure to be utilized, the risks and benefits of my treatment, the alternative treatments available, and the necessity for pre-, 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 sinus lift 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

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Date Printed name and signature of patient, parent or guardian

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Date Printed name and signature of witness

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Date Jacob C. Lueder, DDS, MS Member – Jacob C. Lueder, DDS, MS, PLLC