BONE GRAFT PATIENT INFORMATION AND CONSENT FORM
Complete Dental Center, Drs. Krebs

1. I have been informed and I understand the purpose and the nature of the bone graft surgery procedure. I understand it is being done to enhance the healing shape of my bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire a bone graft to help secure the replaced missing teeth.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are Inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capacities in each patient following the placement of the bone graft.

6. It has been explained that in some instances bone grafts fail and must be removed, I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

7. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the graft. I agree to follow my doctors home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

Patient initials_________________
9. I understand that the graft consists of ground particles of human bone. It has been explained to me that the sterility of the graft material is provided by the manufacturer and not the dentist.

10. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

11. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

12. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

____________________________________  __________________________
Signature of Patient                        Date
______________________________          If the patient is unable to sign or is a minor
Witness                                    (signature of parent or legal guardian)
____________________________________  __________________________
Relationship to Patient