Matthew Bagnulo, DDS | Family Dentist

CONSENT FOR TOOTH EXTRACTION WITH BONE GRAFTING

Patient Name: _____

An explanation of your need for the extraction and bone grafting in the socket and guided tissue regeneration, their purpose and benefits, the surgery related to this procedure, and the possible complications as well as alternatives to its use were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provided the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Suggested Treatment: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reason for this extraction has been explained to me. The tooth/ teeth to be removed are: tooth/ teeth # _____

I have been informed that in areas of my jaw where I will be having teeth removed, there would be benefit to simultaneous bone grafting to help prevent bone loss.

Description of the Procedure: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw bone surface, teeth are removed, the extraction sites are cleaned of any infected tissue, the graft material placed into the extraction sockets and on the surface of the bone and then a membrane may be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth, over the bone graft and membrane. Part of the membrane will be exposed.

Risks Related to the Procedure: Risk related to the surgery with extractions and ridge bone regeneration by the use of bone grafts might include, but are not limited to: fracture of the tooth/ teeth during the extraction, dislodging of a tooth or part of a tooth into the upper jaw sinus, post-surgical infection, bleeding, swelling pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot and cold or sweets or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness of discoloration at the site injection of the anesthetics.

Alternatives to the Procedure: These may include: (1) No treatment, with the expectation of the advancement of my condition resulting in greater risk of complications including, but not limited to, bone loss, pain, infection, possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic results. (2) Building up the ridge with soft tissue grafting which would not increase the possibility of using dental implants. (3) Extending the depth of the cheek pouch by surgery with or without the use of a soft tissue graft would not increase the possibility of using dental implants or the aesthetics or phonetics related to design of a fixed bridge.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, assurance has been given to me the proposed surgery will be completely successful in eradicating pockets, infection, or further bone loss or gum recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exits the risks of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advance involvement, despite the best of care.

CONSENT FOR TOOTH EXTRACTION WITH BONE GRAFTING, CONT.

Consent for Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for modification or change from anticipated surgical plan. These may include, but are not limited to extraction of hopeless teeth enhance haling of adjacent teeth, the removal of hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions: I understand that excessive smoking and/ or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so the healing may be monitored and the doctor can evaluate and report on the success of the surgery.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

PATIENT ENDORSEMENT

My endorsement (signature) to this form indicates that I have read and fully understand the terms used within the document and the explanation referred to or implied. After thorough consideration, I give consent for performance of any and all procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND AUTHORIZATION THAT I AM ABOUT TO SIGN FOR PROPOSED TREATMENT DESCRIBED ABOVE. I ACCEPT THE RISKS OF HARM IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULTS OF THIS TREATMENT.

_____
[Date]

_____
[Printed Name of Patient, Parent or Guardian]

_____
[Signature of Patient, Parent or Guardian]

_____
[Printed Name of Witness]

_____
[Signature of Witness]

_____
[Signature of Attending Doctor]