**AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett**

**PATIENT'S CONSENT FOR BONE REGENERATIVE PROCEDURES**

***Diagnosis:*** My periodontist has advised me that I have alveolar bone resorption (bone loss of the upper or lower jaw bone). I understand that the bone has deteriorated because of periodontal disease, trauma from a dental prosthesis, or trauma from physical injury to the bone.

***Recommended Treatment:*** I understand that local anesthetic, antibiotics and other substances may be applied to the roots of my teeth. During this procedure, my gum will be opened (flapped) to permit better access to the roots of the teeth and/or to the eroded bone. Graft material will be placed in the areas of bone loss around the teeth. Graft materials include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes (barriers) may be used with or without graft material, depending on the type of bone defect present. My gum will then be sutured back into position. I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These modifications or changes may include, 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 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 surgery 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 operated areas and to make my oral hygiene more effective. It should also enable dental professionals to better clean my teeth.

***Principal Risks and Complications:*** I understand that a small number of patients do not respond successfully to bone regenerative procedures and in such cases the involved teeth may be lost. These complications include, but are not limited to post-surgical infections, bleeding, swelling and pain; facial discoloration; transient but occasional permanent numbness of the jaw, lip, tongue, teeth, chin, or gum; jaw joint injuries or associated muscle spasm; transient but occasional permanent increased tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gum upon 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; impact on speech; allergic reactions; and accidental swallowing of foreign matter. Human donated graft tissue is tested for infectious diseases and studies show the processing of the graft (removal of human components) also deactivates infectious disease. There has also never been an infectious disease transmission with these grafts, yet the risk for transmission is not zero. For patients who are taking or have taken medications (pills or injectable/intravenous) for cancer or osteoporosis such as bisphosphonates (Prolia,Fosamax, Didromel, Boniva, Aredia, Actonel, Skelid, Reclast and Zometa etc.) there is an increased risk for osteonecrosis or loss of bone or part of the jaw due to non-living bone tissue. Treatment for osteoporosis can be very easy to manage or very difficult and painful. In very rare cases it may be necessary to leave a small piece of tissue if the surgical procedure to retrieve it is too extensive. The exact duration of any complications cannot be determined and they 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 satisfactory. 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 teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure.

***Alternatives To Suggested Treatment:*** I understand that 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 with periodontal disease 3) non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt to further reduce bacteria and tartar under the gumline 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 result in the worsening of my condition and the premature loss of teeth.

***Necessary Follow-up Care and Self-Care:*** I will need to come to my appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. I know that it is important to abide by the specific prescriptions and instructions given by the periodontist. I have received written pre-surgical and post-operative care instructions.

***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, the treatment should provide benefit in reducing the cause of my condition and should produce healing that will help me retain my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even 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 or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public without my permission.

**I HAVE BEEN FULLY INFORMED OF THE SURGICAL PROCEDURE, BENEFITS, RISKS AND ASSOCIATED PROCEDURES. I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND HAVE HAD ADEQUATE TIME TO REVIEW THIS DOCUMENT. I WILL COMPLY WITH THIS DOCUMENT AND MY PERIODONTIST/STAFF HAS ANSWERED ALL MY QUESTIONS TO MY SATISFACTION.**

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| Patient's Printed Name | Signature | Date |
| Witness Printed Name | Signature | Date |
| Doctor's Printed Name | Signature | Date |