AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett

PATIENT'S CONSENT FOR MAXILLARY SINUS AUGMENTATION

Diagnosis: My periodontist has advised me that I have alveolar bone resorption (bone loss of the upper or lower jaw bone), due to migration of the sinus cavity or periodontal bone loss (bone loss around the teeth), or a combination of both. Chronic trauma from a removable dental prosthesis or physical trauma to the bone may also have caused this bone deterioration.

Recommended Treatment: In order to treat this condition and facilitate the placement of dental implants, my periodontist has recommended that my treatment include maxillary sinus augmentation to eliminate or close this sinus cavity to allow the formation of bone in which to place dental implants. I understand local anesthetics, antibiotics and other substances may be applied to the healing sites and/or prescribed systemically. During the procedure, my gum will be opened (flapped) over the upper jawbone to allow a window or opening into the sinus. Various types of graft material may be used. These materials may include my own bone, purified bovine bone, synthetic bone substitutes or bone obtained from tissue banks (allografts). Bone obtained from tissue banks will be irradiated to sterilize the graft. A resorbable tissue barrier (does not need to be removed) or non-resorbable (needs to be removed) will be placed over the window in the bone. My gum tissue 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 may include, but are not limited to 1) termination of the maxillary sinus augmentation procedure 2) termination of the maxillary sinus augmentation procedure and implant placement if part of the original surgery outline.

Expected Benefits: The purpose of maxillary sinus augmentation is to allow the placement of dental implants in the maxillary (upper) posterior jaw bone. It is anticipated that bone graft materials placed into this cavity will form bone in 6 to 9 months, thus increasing the available bone in which to place dental implants. A more favorable prognosis is expected with increased bone as a longer implant may be used.

Principal Risks and Complications: I understand that complications may result from maxillary sinus augmentation, drugs, and anesthetics. 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; cracking or bruising of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; and injury to adjacent teeth. For the maxillary sinus cavity, there may be bleeding or hematoma within the sinus, which may be expressed through the nose. Chronic or long-term sinus infection may occur, as well as swelling that may be transient or persistent. Some complications may require additional surgical procedures performed by other health professional specialists. 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 potentially 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. 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, nutritional problems, smoking, alcohol consumption, inadequate oral hygiene, and medications that I have been 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 procedure.

Alternatives to Suggested Treatment: Alternative treatment includes – No Treatment. However, without bone augmentation, the placement of implants may be prohibited; or if a slight amount of bone is present then there will be a poor to hopeless long-term prognosis for the implants.

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 understand that my personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

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 a periodontist cannot predict certainty of success. There exist the risks 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.

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