TOOTH EXTRACTION AND BONE GRAFTING

AUTHORIZATION AND CONSENT FOR TOOTH EXTRACTION AND BONE GRAFTING IN CONJUNCTION TO ATTEMPT RIDGE AUGMENTATION

DESRIPTION OF THE PROCEDURE: After anesthetic has numbed the area to be operated on, the gum is reflected from the jaw bone surface, teeth are removed, the extraction sites are cleansed of any infected tissue, the graft material is placed into the extraction sockets and on the surface of the bone. A Guided Tissue Barrier Membrane may be placed over the grafted bone area to prevent gum cells from entering the wound and stopping bone regeneration and to aid in the retention of the bone graft. Finally the gum is sutured back around the teeth and/or together.

DESCRIPTION OF THE GRAFT MATERIAL: Bone tissue harvested from the other areas of your mouth and/or allograft material which is derived from a human source. Once the allograft bone has been harvested, it is processed under sterile conditions to remove all proteins and any source of infection, leaving a calcium substrate.

ALTERNATIVE TO THE PROCEDURE:

- No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including but not limited to bone loss, pain, infection and possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic result.
- Building up the ridge with soft tissue grafting which would not increase the possibility of using dental implants.

CONSENT

1. It has been explained to me of the need for a dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.
2. I have been informed that in areas of my jaw where I will be having teeth removed, there would be benefit to the support of conventional dental prosthetics or for the anchorage of dental implants if simultaneous bone grafting is performed.
3. I understand that the risks of the recommended treatment include, but are not limited to: fracture of the tooth/teeth during extraction, retention of part of the root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, post surgical bleeding, swelling, pain, facial discolouration, 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 or cold, sweet or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between the teeth). Risks related to the anesthetic might include but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness, or discoloration at the injection site.

4. I understand that during surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to; extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completing all 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 doctor.
5. No guarantee, warranty or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. It is anticipated that the surgery will provide benefit in the 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 exists the risk of failure, relapse, selective retreatment or worsening of my present condition, including the loss of certain teeth with advanced involvement despite the best of care.
6. I understand that excessive smoking and/or alcohol intake may affect gum and bone healing and may limit the successful outcome of the surgery. I agree to follow the instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery, so that healing may be monitored and the doctor can evaluate the success of the surgery.
7. I consent to photography, video recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.
8. I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.