

Informed Consent for Bone Block Grafting

Diagnosis: After a careful examination and study of my dental condition, Dr. Paul Giuliani has advised me of insufficient bone volume for dental implant placement.

I, _____ authorize and request that Dr. Giuliani perform the following corrective surgery:

Donor Site: 1) _____ Ramus 2) _____ Symphysis 3) _____ Donor Tissue

Anesthesia: 1) _____ Local Anesthesia 2) _____ Oral Sedation 3) _____ IV Sedation

____ **Recommended Treatment:** In order to treat this condition, Dr. Giuliani has recommended that my treatment include taking a block of bone from the back lower portion of my jaw, the front (chin) area of my lower jaw, or from a donor, and placing it into the site noted above. I understand that this block graft phase, once healed, is followed by an implant surgical phase.

____ **Surgical Phase of Procedure:** Dr. Giuliani has extensively discussed the proposed surgery noted above, including the expected benefits and alternatives to treatment. If I am to receive medicine to relax me (I.V. Sedation, oral sedation, or general sedation), I have been advised of the benefits and risks. I have read and understand the instructions pertaining to sedation. I understand that a local anesthetic will be administered to me as part of the treatment.

____ I understand that the healing phase of surgery varies from patient to patient and case to case. I understand that dentures or partial dentures that place pressure on the surgical site are to be avoided for 1-2 weeks following surgery until Dr. Giuliani authorizes the use. I understand that smoking is not permitted during the healing phase of block grafting.

____ I further understand that if during surgery the clinical situation turns out to be unfavorable for the block graft, Dr. Giuliani will make a professional judgment to manage this situation. This includes canceling the procedure, supplemental bone grafting, and supplemental soft tissue.

Expected Benefits: The purpose of block grafting is to provide adequate volume of bone to support a future dental implant. Implants provide support, anchorage, and retention for the artificial replacement.

____ **Principal Risks and Complications:** I understand that a smaller number of patients do not respond successfully to a block graft. In such cases, the block graft may have to be removed and replaced. Because each patient's conditions are unique, long-term success may not occur.

___ I understand that complications may result from the implant surgery, drugs, or anesthetics. These complications include, but are not limited to, post-surgical jaw infection, bleeding, swelling and pain, facial discoloration, transient or permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient or 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 TMJ pain/dysfunction, osteitis (dry socket), damage to teeth or dental work, impact on speech, allergic reactions, accidental swallowing of foreign matter, need for additional treatment of surgical repair, and the possibility of the need for other surgery or hospitalization. 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 gums and bone will heal. I understand that there may be a need for a revision procedure if the initial results are not satisfactory. In addition, the success of block bone 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 Dr. Giuliani any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by Dr. Giuliani and taking all medications as prescribed are important to the ultimate success of the procedure.

___ ***Alternatives To Suggested Treatment:*** I understand that alternatives to block bone surgery include: no treatment, removable appliances, and other procedures depending upon circumstances. However, continued wearing of ill fitting appliances can result in further damage to the bone and soft tissue of my mouth, and proper fitting appliances will still not stop the eventual loss on bone matter from my jaw unless they are supported by implants.

___ ***Necessary Follow-up Care and Self Care:*** I understand that it is important for me to continue to see my dentist regularly. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

___ I understand that smoking or alcohol intake may adversely affect gum and bone healing, and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by Dr. Giuliani and (2) to see Dr. Giuliani and/or my dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

___ ***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, Dr. Giuliani cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my dental implants and surrounding teeth, including the possible loss of certain teeth or implants, despite the best of care.

___ ***Publication or Records:*** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

PATIENT CONSENT

I have been fully informed of the nature of block bone surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Giuliani. After thorough deliberation, I hereby consent to the performance of block surgery and anesthesia as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Giuliani.

I CERTIFY THAT I HAVE READ AND FULL UNDERSTAND THIS CONSENT DOCUMENT

Signature of Patient or Guardian

Date

Signature of Witness

Date

Signature of Doctor

Date