Sinus Lift/ Maxillary Re-contouring Informed Consent

I, _____ (**printed name**) authorize and request that Dr. Paul Giuliani perform corrective surgery on my upper jaw (maxilla). The operation is planned to implant a bone substitute material, freeze dried demineralized bone, irradiated bone, and/or hydroxyapatite, into the floor of the sinus in the hope that new bone will be incorporated into the material so that an implant(s) might be placed. In addition, if necessary for treatment, Dr. Giuliani may need to re-contour the maxillary bone to create a more suitable foundation for a dental prosthesis and/or dental implant(s).

I understand that a second procedure will be needed to place the dental implant(s) if it is deemed by Dr. Giuliani that simultaneous placement of the implant(s) concurrent with this surgery is not recommended. It is the intention that the implant(s) will become stable and act as anchors for fixed or removable bridges and/or dentures. If new bone does not incorporate into the grafted material then a different prosthetic option will need to be considered.

Dr. Giuliani has explained and described both the sinus lift operation and the maxillary re-contouring operation to my satisfaction. I have had an opportunity to research the procedures on the Internet, and all of my questions have been answered to my satisfaction. It is understood that although excellent results are expected, no guarantee can ever be fully made to ensure the success of the treatment.

I have been informed and understand that occasionally there are complications of surgery, drugs and anesthesia, including, but not limiting to:

1. Pain, swelling, and post-operative discoloration of the face, neck and mouth.
2. Numbness and tingling of the upper lip, chin, gums, teeth and palate, which may be transient, but may be permanent.
3. Infection of the bone that might require further treatment, including hospitalization and surgery.
4. Inappropriate, delayed, or non-union of the synthetic bone material and the normal bone, or a lack of adequate bone growth for implant(s) placement.
5. Bleeding which may require blood transfusions or control measures.
6. Limitation of jaw function.
7. Stiffness of facial and jaw muscles.
8. Injury to the teeth.
9. Referred pain to the ear, neck and head.
10. Post-operative complications involving the sinuses, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the upper cheek and eyes.
11. Post-operative unfavorable reactions to drugs, such as nausea, vomiting, and allergy.
12. Possible loss of teeth and bone segments.
13. Possible bruising and/or discoloration of the face, usually temporary.

I further understand that I am to refrain from the use of alcohol and/or non-prescribed medications during the treatment period. If sedation or general anesthesia is used, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

I understand that Dr. Giuliani will give his best professional care towards accomplishment of the desired results. I understand that I can ask for recital of all possible risks attendant to phases of my care at anytime. I have discussed any questions I have about this consent form with Dr. Giuliani and I am free to withdraw from treatment at anytime.

I certify that I have had the opportunity to read and fully understand the terms and words within this consent form and the explanations referred to. I also state that I read and write English.

I understand this consent form and I acknowledge that Dr. Giuliani has answered all of my questions related to this procedure. I give permission to Dr. Paul Giuliani to perform this procedure:

Date: _____

Patient Signature: _____

Dr. Paul Giuliani: _____