INFORMED CONSENT

Bone Grafting

Socket preservation, ridge augmentation, and sinus augmentation

Please read this form carefully and ask us about anything that is unclear before you sign.

PATIENT NAME _____ DATE OF BIRTH _____

TREATING DOCTOR _____ DATE OF PROCEDURE _____

1 Recommended Treatment

I give my consent to the treating doctor named above, and to the dental team working under the doctor's direction, to perform the following bone grafting procedure(s) on me or my dependent (the "Recommended Treatment"):

- ☐ **Socket (ridge) preservation** — graft placed in an extraction site
- ☐ **Ridge augmentation** — rebuilding the width and/or height of the jawbone
- ☐ **Sinus augmentation (sinus lift)** — adding bone beneath the sinus in the upper back jaw
- ☐ **Block or other grafting technique**
- ☐ Other:_____

Graft site(s) / area(s): _____

GRAFT MATERIALS (DOCTOR TO CHECK; THE SOURCE OF EACH HAS BEEN EXPLAINED TO ME)

- ☐ **Autograft** — my own bone, taken from another site in my mouth or body
- ☐ **Allograft** — processed human donor bone ("banked bone")
- ☐ **Xenograft** — processed animal-derived bone (for example, bovine)
- ☐ **Alloplast** — synthetic bone substitute
- ☐ **Barrier membrane** (resorbable or non-resorbable)
- ☐ **Growth factors from my own blood** (PRF / PRP)

I understand that I may ask about, and may decline, any graft material for personal, religious, ethical, or medical reasons.

I also consent to any additional procedure(s) the doctor considers necessary for my well-being based on findings made during the course of the Recommended Treatment, and to the administration of local anesthesia. If sedation is planned, I will sign a separate sedation consent. The nature and purpose of the Recommended Treatment have been explained to me, and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed.

2 Purpose and What to Expect

Bone grafting is recommended to preserve or rebuild jawbone lost to tooth loss, infection, or other causes so that dental implants or other tooth replacement can be placed predictably. The graft usually needs several months to mature before an implant can be placed; timing depends on the site and the material used. Grafting does not guarantee that enough bone will form for an implant, and the graft may be partly or completely lost.

3 Treatment Alternatives

Alternative methods of treatment have been explained to me, including the following (doctor to check those discussed):

- ☐ **No grafting** — the bone may continue to shrink, and implants or other replacement options may be limited or not possible
- ☐ **Shorter, narrower, or angled implants** that may not require grafting
- ☐ **Removable partial or complete denture**
- ☐ **Fixed bridge** supported by neighboring teeth
- ☐ **A different graft material or technique**
- ☐ Other:_____

Having considered these alternatives, I wish to proceed with the Recommended Treatment described above.

4 Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and with performance of the Recommended Treatment. These include, but are not limited to, the following:

GENERAL RISKS

1. **Drug reactions and side effects.** Including allergic reactions to medications, anesthetics, or antibiotics.
2. **Pain, bleeding, and infection.** Post-operative pain, bleeding, oozing, and soft-tissue and/or bone infection. In rare cases an infection can spread to the face, neck, or other areas and require urgent treatment.
3. **Swelling and stiffness.** Bruising and/or swelling, and restricted mouth opening for several days or weeks, or, rarely, longer.
4. **Delayed healing.** Healing may be slower than expected, necessitating post-operative care and treatment.
5. **Health and lifestyle factors.** Smoking or vaping, nicotine use, uncontrolled diabetes, a weakened immune system, and certain other conditions or medications increase the risk of infection, delayed healing, and treatment failure.
6. **Medications and prior radiation.** If I take medications that affect bone (such as bisphosphonates or denosumab) or have had radiation therapy to the head or neck for tumors/cancer, I am at higher risk for poor bone healing or bone death (osteonecrosis) that may never completely resolve and may require surgery or other treatment.

GRAFT-SPECIFIC RISKS

7. **Graft failure.** Failure, loss, infection, or rejection of the graft or the membranes used to contain it. The graft or membrane may become exposed through the gums, and graft particles may be lost. This may require removal, repeat grafting, or a delay in later treatment.
8. **Not enough bone.** The graft may not produce enough bone for an implant, or the bone may shrink over time.
9. **Graft-material risks.** If I have elected a banked bone or bone substitute graft, there is a rare chance of disease spread from the processed bone. Allergic or other reactions to graft materials or membranes are possible but uncommon.
10. **Donor site (if my own bone is used).** Additional pain, swelling, bruising, numbness, infection, or healing problems at the site where bone is taken.
11. **Sinus complications.** Possible involvement of the sinus cavity and creation of an opening from the mouth into the nasal or sinus cavity. In a sinus lift, the sinus lining may tear, graft material may enter the sinus, or a sinus infection may develop. These may require medication, additional treatment, or surgical repair at a later date.
12. **Nerve injury.** Injury to nerves from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or lost sensation, numbness, tingling, or pain (possibly of an electric-shock nature) of the face, cheek(s), lips, chin, teeth, gums, and/or tongue, with possible alteration or loss of taste. This may resolve over time but, in some cases, may be permanent.
13. **Damage to neighboring teeth.** Damage to, or fracture of, adjacent teeth, fillings, crowns, or other restorations.
14. **Gum appearance.** Discoloration and appearance changes of the gum tissue, gum recession, or an unsatisfactory cosmetic result.
15. **Jaw fracture.** A fracture of the jaw is rare but may require additional treatment.
16. **Jaw joint (TMJ) problems.** Pain and/or limited movement of the jaw joint, either temporary or permanent, which may require further treatment.
17. **Local anesthesia effects.** As a result of the injection or use of local anesthesia, there may be swelling, jaw muscle tenderness, or numbness, tingling, or pain of the tongue, lips, teeth, jaws, and/or facial tissues, and altered or lost taste. This is typically temporary but, in rare instances, may be permanent.

5 After Treatment and My Responsibilities

- I will follow all post-operative instructions, including medications, rinses, diet, and oral hygiene.
- I will not place pressure on the graft site. I will wear a temporary denture or partial only if it has been adjusted for the graft site.
- If I have a sinus lift, I will avoid blowing my nose, drinking through a straw, and holding in sneezes (sneeze with my mouth open) as instructed.
- I will avoid smoking, vaping, and nicotine as advised, because they reduce graft success.
- I will attend all follow-up visits and any imaging needed to evaluate the graft before further treatment.

6 Photographs and Records (Optional)

My care may be documented with photographs, X-rays, 3D scans, and clinical notes, which become part of my dental record. In addition, I may choose whether my records can be used for professional education, case presentation, or publication:

☐ I **agree** to the use of my records for education and professional case presentation, with all identifying information removed (no name, date of birth, or other identifiers).

☐ I **do not agree**; my records may be used only for my own care and the operation of this practice.

My choice will not affect my care. I will be asked for separate written permission before any image showing my face or other identifying features is published.

7 Patient Acknowledgment

By signing below, I confirm that:

- The nature and purpose of the Recommended Treatment, its expected benefits and risks, and the alternatives — including no treatment — have been explained to me in terms I understand.
- I have had the opportunity to ask questions, and they have been answered to my satisfaction.
- The health history, medication, and allergy information I have given this office is complete and accurate, and I will report any change before treatment.
- I understand that the risks listed in this form are not a complete list, that no guarantee has been made about the result, and that additional or different treatment may be needed.
- I understand that I may ask questions, or withdraw my consent, at any time before treatment begins.
- I have been offered a copy of this signed form.

I consent to the Recommended Treatment described in this form.

8 Signatures

☐ Interpreter or language assistance used — name / ID:_____

_____ _____

Patient / parent / legal guardian signature | Date and time

_____ _____

Printed name | Relationship to patient (if signer is not the patient)

_____ _____

Witness signature | Witness printed name

Doctor's statement. I have discussed the nature, purpose, benefits, risks, and alternatives of the Recommended Treatment with the patient (or the patient's legal representative), have answered their questions, and believe they understand and consent.

_____ _____

Treating doctor signature | Date and time