CONSENT FOR GRAFTING

_____
Patient's Name Date

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

1. My condition has been explained to me as:
   _____
   _____

2. The procedure to treat the condition has been explained to me as:

   A. CORTICAL BONE GRAFTING - This involves taking a segment of bone from either the outer portion of the jaw toward the back or a segment of bone from the front of the chin area and transferring it to the site(s) where bone support has been determined to be deficient (usually for placing a dental implant).

   B. BANKED BONE (freeze-dried, lyophilized, demineralized, xenografts) OR BONE SUBSTITUTES - On occasion, donated, processed, or artificial bone substitutes are used to graft extraction sockets or are used to supplement the patient's own bone graft.

   C. FREE GINGIVAL and/or CONNECTIVE TISSUE GRAFTING - This involves taking a segment of tissue from the palate.

   D. BANKED TISSUE (processed) - On occasion, donated acellular tissue matrix product substitutes are used to supplement the patient's soft tissue needs.

3. I have been informed of possible alternate methods of treatment (if any) including:
   _____
   _____

   I understand that these and other forms of treatment or no treatment at all are choices I have and the risks of those choices have been presented to me.

4. My doctor has explained to me that there are certain risks and side effects associated with my proposed treatment and in this specific they include, but are not limited to:

_____ A. Post-operative discomfort and swelling requiring several days of at-home recovery.

_____B. Prolonged or heavy bleeding that may require additional treatment.

_____C. Injury or damage to the blood supply of teeth next to the graft donor site. That may require root canal treatment on affected tooth, or even result in their eventual loss.

_____ D. Post-operative infection that may adversely affect the graft and require additional treatment.

_____ E. Scarring at the site of incisions inside the mouth.

_____ F. Injury to the sensory nerves in the donor or recipient sites, resulting in numbness, tingling, pain, or other sensory disturbances in the chin, lip, cheek, face, teeth, gums, and which may persist for several weeks or months, or rarely may be permanent.

_____ G. Failure of the graft to integrate with the recipient tissues, loss of vitality or other unexpected loss of the graft.

_____ H. Biologic/synthetic membranes or dressings are often used to contain and protect the graft may be unexpectedly lost in which case the graft may be adversely affected.

_____ I. Allergic reactions (previously unknown) to any materials or medications used.

_____J. Any type of graft may need more treatment such as a procedure to build up or thin the graft.

_____K. Other_____

INFORMATION FOR FEMALE PATIENTS

_____K. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

I have been told that during the treatment things may change or you may find another condition needing a procedure other than the one planned above. I authorize my doctor and his staff to use professional judgment to perform a different type of grafting procedure or use a different grafting material to complete my surgery if necessary.

It has been explained to me, and I understand that perfect results cannot be guaranteed.

CONSENT

I certify that I speak, read and write English, that I fully understand this consent form for surgery, and that all blanks were filled in prior to my signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness's Signature	Date