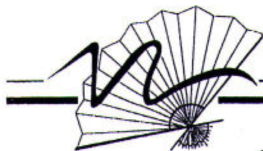

Clifton E. Nakatani DDS MSD
Practice Limited to Periodontics and Implants

CONSENT FOR BONE GRAFT AND SINUS GRAFT SURGERY

PURPOSE: I understand that bone graft surgery is intended to replace lost bone for reconstructive or esthetic purposes. I understand that sinus lift surgery involves raising the height of the floor of the sinus and placing bone grafting material to create a better situation for the subsequent placement of a dental implant. I acknowledge that alternatives to these procedures have been explained to me. I realize that consequences of not having the bone graft surgery or sinus lift surgery could be but are not limited to: infection or bone loss, infection or loss of gum tissue, infection, sensitivity of teeth, looseness of teeth leading to the need for extraction, etc. I acknowledge if the bone graft surgery and/or sinus lift procedures are not performed, it may not be possible in the future to place implants or a bone graft due to changes in my oral or medical conditions.

INFECTION: In spite of how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile environment, infections may occur post-operatively. At times these may be of serious nature. Should severe swelling occur, particularly when accompanied with fever or malaise, attention should be received as soon as possible. It is the patient's responsibility to contact this office should the foregoing occur. Such infection may interfere with the success or longevity of the bone graft and ultimate success of the implant.

INJURY TO THE NERVES: There is a slight possibility of injury to the nerves of the face and tissues of the oral cavity during administration of local anesthetic or during surgery which may cause numbness of lips, tongue, floor of the mouth, and/or cheeks, etc. This numbness may be of a temporary or, rarely, permanent, in nature.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth (i.e. brushing, flossing, utilizing anti-bacterial rinse, etc.). I agree to report for post-operative appointments following my surgery so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of the surgery upon completion of healing.

RELATED COMPLICATIONS: These may include thromboplebitis (inflammation of blood vessels), injury to adjacent teeth present, bone fracture, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc. I understand that bone remodels while healing and there is no method to predict the ultimate or final volume of bone. In some cases following healing, additional bone grafting may be necessary to achieve the final results desired.

POSSIBILITY OF FAILURE: I understand that in some instances bone grafts fail due to mal-union, delayed union or non-union of the donor bone graft to the recipient bone site and must be removed. I understand that lack of adequate bone growth in to the bone graft replacement material may also result in failure of the graft. It is possible that reconstructive surgery may be necessary associated with and/or following removal of the graft. I understand that alternative prosthetic procedures may be required should the bone graft fail.

ANESTHESIA:

- [x] Local anesthesia will be used.
- [ ] Local anesthesia with oral anti-anxiety medication. **If you take this medication, <u>YOU CANNOT DRIVE</u>. You will need a driver to stay in our office for the duration of the surgical visit.**

ANESTHESIA RISKS include discomfort, swelling, bruising, infection, prolonged numbness, and/or an allergic reaction.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be completely successful in function or appearance (to my complete satisfaction). It is anticipated (hoped) that the treatment will be permanently retained but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long term success cannot be promised.

BLOOD CONCENTRATES: I give my consent to use my own blood in the surgical procedure utilizing my blood concentrate. The amount of blood drawn for this procedure is approximately 20-60 cc's.

INITIAL X________

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916-421-5555

CONSENT TO UNFORSEEN CONDITIONS: During treatment, unknown conditions may modify or change the original treatment plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I, therefore, consent to the performance of such additional or alternative procedures as may be required by proper dental care in the best judgment of the treating doctor.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to the procedure. I give consent that my records may be used for educational use in lectures or publications provided that my identity is NOT revealed.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed or any other reasonable alternative treatment, that such a decision is my sole responsibility. I acknowledge that risks related to my non-acceptance of treatment for my problem have been explained to me and include, but are not limited to, dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bone, further gum recession, problems with my bite including pain, spasm, headaches, or problems with my jaw joints or associated musculature.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I agree to diligently comply with any and all pre-operative and post-operative instructions given to me. I understand that if I need to and don't return for my follow-up visits, my condition may get to a point where I might need more care or more surgery. I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my treatment. It is my responsibility to timely seek attention should any undue circumstances occur post-operatively. I agree to report for post-operative care appointments following my treatment so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of my treatment upon completion of healing.

NO GUARANTEE OF TREATMENT: No guarantee or warranted results have been offered or promised. I realize that Dr. Nakatani may discover conditions that may require different surgery from that which was planned and I give my permission for those other procedures that are advisable in the exercise of the professional judgment to complete my surgery.

BISPHOSPHONATE DRUG RISKS: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone.

SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and/or reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of periodontal dentistry prior to completing my deliberation and decision.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of this procedure and have received answers to my satisfaction. I recognize that it is my responsibility to fully inform Dr. Nakatani of the condition of my health and any and all problems thereto. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and/or any results from the treatment rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, (1) certifies that I have read and understand the entirety of this document and (2) I am freely giving my consent to authorize Dr. Nakatani and/or all associates involved in rendering any services he/she deems necessary and advisable to treatment of my dental conditions, including any anesthetic agents and medications.

X ______________________________

Name of Patient (Please Print)

X ______________________________ X ________________

Signature of Patient or Legal Guardian Date

As a part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

Clifton E. Nakatani DDS MSD INC. ______________________________ Witness