Consent Form: Maxillary Sinus Bone Augmentation

The purpose of the procedure is developing bone in the maxillary cavity for the placement of dental implants, either at a one-step or at a two-steps process. During the procedure an incision will be made in the soft maxillary tissues, exposing the maxillary sinus wall, opening a bony window through which the sinus membrane will be elevated and the bone graft will be placed. I have been informed that if this procedure was restricted to bone graft placement alone, it will not be possible to insert dental implants until 9 months later, in a separate surgical procedure. I understand that rehabilitation on the dental implants can be preformed only 9 months after placement of dental implants.

Name of patient:

_____

Last Name First Name I.D.

I declare and confirm that I received detailed verbal information from:

Dr. _____

Last name First Name

On bone graft /bone substitutes with or without dental implants in the upper jaw, the details of which are specified below (type, location and quantity):

_____

_____

_____

(hereinafter: the "Principal treatment").

I was informed on the treatment necessary for bone augmentation of the maxillary space and placement of the dental implants, including the expected results and possible alternative treatments under the circumstances of the case. I considered the alternative treatments before choosing this treatment.

I was informed of the possibility that after opening the bony "window" in the sinus wall, it would be found out that the bone graft placement would not be enabled.

I was informed of the side effects of the Principal Treatment, including: : Significant swelling, hemorrhages in the cheek and neck area which will be resolved within ten days, limitation in mouth opening for a few days: significant swelling around the yey at the treatment's side; bleeding from the nostril at the treatment's side which may persist for about two days.

I was also informed of the risks and complications related to the Principal Treatment, including: Infection which may require additional surgical procedure and result in the need for full or partial removal of the bone graft and/or implants; the possibility of an oral-maxillary sinus fistula, which may require an additional surgical treatment;

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significant hemorrhage which may require additional treatment; possible injury to adjacent teeth roots, if there are any; injury to the maxillary nerves, which may cause stinging sensation and/or numbness in the side of the nose and/or in the upper lip and/or in the gums at the treatment's side.
These side effects normally resolve within a few weeks, however, they may become permanent.
It was also explained to me and I understand the importance of continuing treatment at the same clinic and the cooperation between the doctor placing the dental implants and the doctor performing the rehabilitative treatment and I am well aware that the treating staff/doctor would not be responsible for the treatment or its consequences, should I discontinue treatment at my own initiative and turn to other clinic's and/or other doctor for treatment of the implants and the surrounding tissues, without coordinating it with the treating dentist.

Furthermore, I am aware of the importance of providing accurate information regarding my health condition and of following all instructions of the medical staff and/or the treating doctor, including maintaining oral hygiene, and receiving all necessary operative and prosthetic treatments and attending follow-up checkups according to schedule as necessary.
I was informed that the risk of treatment failure and complications is higher among smokers and diabetic patients.
I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after being informed of the risks and complications of anesthesia including loss of sensation in the lip or tongue, hematoma, swelling and limitation in opening my mouth.
Should the Principal Treatment be performed under general anesthesia or under intravenous sedation, I will be informed on the anesthesia technique by an anesthetist.

Date _____ Patient's Signature _____

Name of Guardian (relationship) _____ Guardian's signature (when patients is legally incompetent, a minor or mentally ill) _____

I confirm that I explained to the patient/the patient's guardian* all the aforementioned in detail as required and that he/she signed before me, after I satisfied myself that he/she fully understood my explanation.

Name of Physician _____ Signature _____ License No. _____

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