CONSENT TO SURGERY

Our practice is committed to providing our patients with the finest care possible. We strive for the very best results but healing can vary from person to person. We must inform you of the possible risks associated with the surgery and the alternatives to treatment.

SURGICAL PROCEDURE

□ Extraction: Tooth/ Teeth

□ Dental Implant Placement

□ Ridge/ Sinus Bone Graft

□ Socket Bone graft

□ Soft Tissue (Gum) Graft

□ Frenectomy

□ Pocket reduction procedure

□ Bone grafting for teeth

□ Crown Lengthening

□ Gum Contouring for Cosmetics

□ Biopsy

□ Other ______________________

In order to treat my current periodontal condition, Dr. Towe has recommended that my treatment may include the surgical procedure noted above. I understand that local anesthetic will be administered to me as part of treatment, and that I have the option to choose sedation for relaxation during the procedure.

I have been informed and I understand the purpose and nature of the procedure I am about to receive. My doctor has carefully examined my mouth, and alternatives to this treatment has been explained. I have tried or considered these methods, but I desire this treatment option.

I understand that antibiotics, growth factors and other substances may be applied to the roots of my teeth. I consent to the use of soft tissue and/ or bone graft material either from myself, or from other sources (ie: bovine, porcine, synthetic, or cadaveric) for treatment. The material that will be used (other than my own) has been tested for viruses and bacteria by the most sophisticated and reliable methods available today. I further understand that unforeseen circumstances may call for modification or termination from the anticipated surgical plan.

RISKS AND COMPLICATIONS

I understand that a small number of patients do not respond successfully to periodontal or implant surgery. In such cases, the involved teeth or implants may be lost. The surgery may not be successful in preserving and/ or achieving function or esthetics. Additional procedures may need to be performed if the initial results are not satisfactory. Each patient's condition is unique and long- term success may not occur. I understand that my medical/ health conditions, medications that I am taking, diet and nutritional problems, clenching of my teeth, excessive smoking, alcohol, or sugar may affect healing, and may limit the success of treatment.

I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such possible complications include pain, swelling, infection, bruising, temporary or permanent numbness of the lip, tongue, chin, cheek or teeth, inflammation of vessels, injury to teeth, restricted mouth mobility, gum recession (shrinkage), interference with speech, thermal tooth sensitivity, increased tooth looseness, food impaction between teeth after eating, unaesthetic exposure of crown (cap) margins, accidental swallowing of foreign matter, bone fractures, sinus penetrations, delayed healing, allergic reactions to medications, and other unforeseen complications up to and including death.

PATIENTS WHO HAVE RECEIVED BISPHONATES OR RADIATION

I understand that if I have been treated with oral bisphosphonate drugs or radiation treatment to the jaw bone then there is a risk of severe complications with any dental treatment. Bisphosphonate drugs or radiation treatment to the jaw bone affect its healing capability. Osteonecrosis (dying of bone cells) or infection of the bone or soft tissue may occur, resulting in severe jaw destruction that could require multiple reconstructive surgeries, ongoing intensive therapy, hospitalization, long term antibiotics, and removal of dead bone,

ALTERNATIVES TO TREATMENT

I understand that without treatment any of the following could occur; bone disease, loss of bone, gum tissue inflammation, sensitivity, looseness of teeth, tooth loss, temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, severe infection that can be fatal and other unforeseen events.

Alternatives to implant related procedures such as partial dentures and fixed bridges have been discussed. I understand the reasons I have chosen this treatment. I understand that my restorative dentist completes the crowns on the implants and that these fees are separate.

HOME CARE

I will come for appointments following my surgery as instructed so that my healing may be monitored, and prosthesis adjusted if necessary. It has been explained to me that the long-term success of treatment requires my cooperation and performance of plaque control (home care) as instructed at least twice a day, as well as periodic periodontal maintenance visits. I understand that failure to follow such recommendations could lead to ill effects, which would be my sole responsibility.

PUBLICATION OF RECORDS

I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of dentistry, provided my identity is not revealed.

AUTHORIZATION

I have been fully informed of the nature of the proposed surgery, the procedures to be utilized, the risks and benefits, alterative treatment available, and the necessity for follow-up and self care. I understand English or have had someone translate the meaning of this document to me. I am not under the influence of alcohol or other mind altering substances. I have had an opportunity to ask my questions and discuss my concerns with my doctor to my satisfaction. I request and authorize this treatment for myself. I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Patient Name (please print): ____

Patient Signature: ________________________________ Date: ________________

Witness Signature: _______________________________ Date: ________________