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CONSENT FOR SINUS ELEVATION WITH IMMEDIATE IMPLANT PLACEMENT

PATIENT NAME_____

TOOTH NAME/NUMBER_____

The standard of care requires that we obtain your informed consent before surgery and anesthesia. What you are being asked to sign is your acknowledgement that you have been informed about the treatment of your condition and the known risks by conversations with the doctors and staff as well as printed material provided to you. While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of surgery and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to ask Dr. _ about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other oral surgeons and implantologists.
Please initial below:

1. After careful oral examination and study of my dental condition, my dentist has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct Dr. _____and his assistants to treat my condition.
2. The procedure I choose to treat this condition is understood by me to be the placement of root form implants into the maxillary sinus region. Additional treatment procedures may include a bone graft including materials of human, animal or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage and retention for these teeth.
3. I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and, that as an alternate option although less desirable, I could choose to not undergo the surgery and do nothing. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a bridge, a partial denture, full dentures, or other options. I understand and choose to undergo the placement of root form implants into the maxillary sinus region.
4. I understand that implants will be placed immediately into the sinus cavity following sinus elevation. I understand that my gum tissue will be surgically opened to expose the bone and that the implants will be placed immediately by tapping or threading them into holes that have been drilled into the jaw bone. I understand that the gum tissue will then be

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stitched closed over or around the implant to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that the implants placed will be integrated in 3 to 9 months time, depending on my personal healing ability. I understand that there are inherent and potential risks in any treatment or procedure, and that such complications may require additional treatment, and that in this specific procedure the risks of surgery include but are not limited to:

A. Possible sinus membrane perforation
B. Infection requiring additional treatment or possible removal of the implant
C. Sinusitis, even though in many instances this technique will actually improve sinusitis if present
D. Post-operative swelling and pain
E. Tenderness and stiffness within the chewing muscles or neck area, and difficulty opening your mouth and speaking.
F. Prolonged or heavy bleeding, formation of a hematoma (or blood clot) at the surgery site and bruising
G. Failure of the implant requiring removal of a part or all of the implant at any time after surgery. Failure may include failure of the components including posts, abutments or loss of bone adaption (graft) at any time following surgery.
H. Complications around the implant posts or abutments that require corrective surgery in an attempt to salvage a failing implant may require another integration period of 3 to 9 months time.
I. Complications of local, sedative and general anesthetic agents:
    - allergic reactions
    - nausea and vomiting
    - inflammation, infection or bruising at the injection site
    - headache and dizziness
    - life-threatening reactions including heart irregularities, heart attack, brain damage or death
J. Transient, though on occasion permanent, numbness of the lips, tongue, tooth, chin or gum
K. Transient, though on occasion permanent, increased tooth looseness or sensitivity to hot, cold, sweet or acidic foods

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5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitates an extension or alteration of the planned procedure contained herein. I therefore authorize and request that Dr. _____ and his assistants under their direction perform such procedures as found necessary and administer such drugs and treatments as required in their professional judgment.

6. I have had the opportunity to discuss with Dr. _____ the planned surgical procedure, sinus elevation with immediate implant placement, and my postoperative responsibilities. I understand that following the procedure, and during the healing process I should not smoke, drink heavily or use any drugs not prescribed by my doctor. I should not blow my nose for at least two weeks, and thereafter, not heavily blow my nose for an additional two weeks. I should take any antibiotics prescribed and use pain medication as needed. If I experience an unusual amount of pain I should contact Dr. _____ immediately, as it may signify a problem.

7. I understand that anesthesia given during surgery, and certain prescription medications used after surgery, cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol, and that I must not operate a motor vehicle or any other hazardous equipment while taking these drugs. Further, I agree not to operate a motor vehicle or any other hazardous equipment for at least 48 hours after my release from surgery.

8. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, risks of failure or necessity of additional treatment despite appropriate care do exist. I have been advised that the placement of root form implants into the maxillary sinus region has shown long-term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. I further understand that should removal be required, Dr. _____ will remove the implant at no additional cost. However, should I elect to have another doctor remove the implant, I am solely responsible for all costs and fees incurred in doing so and hereby release Dr. _____ from any such costs and fees imposed by the other doctor.

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9. I understand that the fee I am to be charged has been disclosed to me, is satisfactory to me, and includes no additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. I understand that as a courtesy to me, the office staff will assist in the preparation and filing of necessary insurance claims should I be insured. However, I further understand that the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and in no way alleviates my responsibility to pay for services provided. I understand that some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I understand that I am responsible for paying all co-pays and deductibles at the time when services are rendered and any and all costs that have not been paid for by my insurance within 30 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per annum. I understand that I will be fully liable for all collection costs, including court costs and attorney fees.

10. I agreed to cooperate fully with the recommendations of Dr. _____ while under his/her care, understanding that the long-term success of my treatment depends on personal oral hygiene, completion of recommended dental therapy, regular follow-up care appointments and overall general health. I understand that there will be several follow-up clinical visits with Dr. _____ for the first year following surgery. In addition, I understand it is my responsibility to see the doctor at least once a year for evaluation of implant performance and twice a year for oral hygiene maintenance.

Consent

I hereby certify that I have read this form in its entirety and have had all my questions answered by my doctor. I certify that I understand English and fully understand the terms and words within the above paragraphs. My signature below signifies that I understand the treatment plan that is proposed to me together with its known risks and complications. I hereby give my informed consent for surgery and anesthesia.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____ _____

Signature of Dentist Date

_____ _____

Signature of Witness Date