

PATIENT'S CONSENT FOR MAXILLARY SINUS ELEVATION SURGERY

Name _____ Date ____/____/____ Tooth _____

Upper Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Upper Left
Lower Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower Left

EXPLANATION OF DIAGNOSIS: After having a careful oral examination and study of my dental condition, I have been informed there is insufficient bone height in my upper jaw to place root-shaped dental implants that have adequate length.

RECOMMENDED TREATMENT: To relieve this condition, treatment that includes maxillary sinus elevation (sinus lift) surgery. A local anesthetic will be administered in addition to medications deemed appropriate by doctor, and oral antibiotics may be prescribed.

EXPECTED BENEFITS: The purpose of this procedure is to provide enough bone in the upper jaw to allow placement of root-shaped implants.

ALTERNATIVES TO THE SUGGESTED TREATMENT: Alternatives may include no treatment with the understanding that dental implants are not an option.

GRAFTING: During this procedure, gum tissue will be pulled back, an opening will be created in the wall on the side of my maxillary sinus, and the lining of sinuses will be lifted under which a bone graft will be placed. This graft may include my own bone, synthetic bone substitute, human bone obtained from tissue banks, or a combination of these. Prefabricated membranes may also be used. Which, if non-restorable, require a small additional surgical procedure for membrane removal. Dental implants may or may not be placed at the same time of the sinus lift surgery. Whether implants will be placed at the same time cannot be determined with certainty before the procedure. I understand that implant placement may be delayed for as long as the doctor deems advisable.

PRINCIPLE RISKS AND COMPLICATIONS: Risks related to maxillary sinus elevation surgery include but are not limited to infection, bleeding, swelling, pain, temporary discoloration of the face, increased tooth looseness, tooth sensitivity to hot or cold temperatures, and tooth sensitivity to sweet or acidic foods. Gum shrinkage upon healing may occur and result in elongation of and greater spaces between teeth. Rarely, nerve damage may occur as well as infections that may spread to other parts of the body. Nose bleeds may occur, and local infection may spread to the bone (osteomyelitis). Failure of the bone graft may lead to failure of implants placed in the area or the inability to place implants later. Chronic or acute sinusitis may occur because of this procedure. Existing sinusitis may be aggravated or recur more frequently.

Risks related to anesthetic may include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness, or discoloration at the site of the anesthetic injection. The exact duration of any complications cannot be determined and may be irreversible.

I understand there is no method to accurately predict or evaluate how my gum tissue and bone will heal, and there may be a need for a second procedure if the initial surgery is not satisfactory. I also acknowledge the success of treatment may be affected by medical conditions, dietary and nutritional problems, smoking, alcohol intake, clenching and grinding of teeth, inadequate oral hygiene, and

Initials: _____

medications I may be taking. To my knowledge, I have reported any prior drug reactions, allergies, diseases, symptoms, habits or conditions to the doctor that may relate to this surgical procedure.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful. It is anticipated that surgery will provide benefit in reducing the cause of my condition and produce healing that will enhance the possibility that I may retain my teeth longer. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, even with the best of care, there exists the risk of failure, relapse, need for selective re-treatment, or worsening of my present condition, including the possible loss of certain teeth due to advanced involvement.

CONSENT DUE TO UNFORSEEN CONDITIONS: Unforeseen conditions may be discovered during surgery that may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to extraction of teeth, the removal of parts of teeth, and the inability to start or complete the sinus lift procedure. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include but are not limited to additional work, or referral to other dental or medical specialist. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that **smoking and/or alcohol intake may affect gum healing and may adversely affect the successful outcome of my surgery.** I agree to follow instructions related to my own daily care of my mouth and the use of prescribed medications. I agree to report for appointments following my surgery so the doctor may monitor my healing, evaluate and report the outcome of surgery, and if necessary, adjust prosthetic appliances. I also understand that since existing restorative dentistry is an important factor in my healing and ongoing care, it is important for me to see my regular dentist as recommended.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed without my permission.

PATIENT'S ENDORSEMENT: My endorsement (signature) on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of all procedures related to maxillary sinus elevation surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Signature _____	Date ____/____/____
Patient / Responsible party	
_____	Relationship _____
Print name	to patient
_____	Date ____/____/____
Signature of witness	