CONSENT FOR RIDGE AUGMENTATION SURGERY

Patient's Name Date

PURPOSE: This treatment is termed "ridge augmentation" and is an effort to improve ridge form in order to support, or otherwise help stabilize, a denture, dental implant or bridge.

TREATMENT: Augmentation is accomplished by placing bone or bone substitute materials through an incision(s) in the gum and into a tunnel beneath the gum tissue on the top of the inadequate bony ridge. After a suitable healing time, a new denture, bridge or implant may be placed, or the old appliance may be modified. During the healing phase, the old denture can often be modified and worn, although a very restricted diet is required. Rarely, the old appliance cannot be worn at all during healing. On occasion a secondary procedure called a "vestibuloplasty" (to gain more ridge surface) may be necessary in conjunction with the augmentation procedure in order to obtain the best possible result for the new appliance.

ALTERNATIVES TO TREATMENT: If this treatment is not done, I understand my choices are: to continue wearing the denture or appliance I have at present; remake my present appliance to try to improve the fit; undergo surgical procedures to reposition muscle attachments or otherwise attempt to extend the deficient ridge; surgically place implants to support my present appliance; or:

_____

RISKS AND COMPLICATIONS include, but are not limited to:

_____1. Numbness, pain or tingling of the chin, lips, tongue (including possible loss of taste sensation), cheek or gum tissue. These symptoms may persist for weeks, months, or, in rare instances, may be permanent.
_____2. Swelling and discomfort and some difficulty chewing and swallowing for a time.
_____3. Bleeding, bruising and possible formation of a hematoma (clot) in the tissues of the floor of the mouth that may remain for several days and require additional care.
_____4. Artificial grafting material may settle somewhat with use and some of the newly-gained ridge form may be lost. Grafted bone may also gradually decrease in height and form over time.
_____5. Occasionally, grafted material will migrate into surrounding tissues and require further treatment. Although uncommon, graft material may press against nerve structures, causing enough discomfort that some or all the graft may require removal.
_____6. Allergic reactions to drugs or medicine used during treatment.
_____7. Damage to adjacent teeth or tooth roots.
_____8. Fracture of the jaw or thin portions of the jaw.
_____9. Infection that may require additional treatment.

_____10. **ANESTHESIA**

The anesthetic I have chosen for my surgery is:

_____☐ Local Anesthesia
_____☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
_____☐ Local Anesthesia with Oral Premedication
_____☐ Local Anesthesia with Intravenous Sedation

_____11. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

_____12. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR **SIX (6) HOURS** PRIOR TO YOUR ANESTHETIC. T**O DO OTHERWISE MAY BE LIFE-THREATIENING!**
D. **However,** it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

_____13. No guaranteed or warranted results have been offered or promised. I realize my doctor 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 professional judgment to complete my surgery.

Surgical time out _____

CONSENT

I have had an opportunity to have all my questions answered by my doctor and I certify that I speak, read, and write English. No guarantees of either a cosmetic or functional nature have been made to me regarding the outcome of my surgery. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and the anesthesia I have chosen.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

Print Witness' Name and Address

Unless sooner terminated in writing, this consent shall remain in force for 60 days from the date it is signed by the Patient. A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original. 05/2012