PAUL A. BRANNEN, DMD, LLC
— General Dentist Providing Oral Surgery Services —

Bone Graft Informed Consent

I ____, understand that when a tooth is extracted, the underlying bone tends to atrophy (shrink). Bone grafting is a method to reduce or offset this bone atrophy after extraction(s), or to supplement bone around an implant, in a large sinus cavity, or to treat pocketing around a tooth. Listed below are several types of bone grafting materials/techniques for you to select from. Please indicate your preference by initialing beside your selection:

____ **Self** (Autogenous) graft: transplants or grafts your own harvested bone, either small particles or in block form, for jaw rebuilding - very effective but harvesting your bone is more painful and expensive.

____ **Donor Human** (Allograft) OR **Donor Bovine** (cow) graft: pre-packaged cadaver bone particles - very effective and reasonable cost, but there exists a rare risk of disease (estimated currently at less than 1 occurrence out of every two million uses), and will preclude blood/tissue donations for 1 year or more at most blood banks.

____ **Synthetic** (Alloplast) graft: places synthetic/chemically derived bone substitutes - less effective but no risk of disease transmission.

____ **Decline**: I have decided not to have you perform the bone graft procedure. I also understand the potential outcome of having no bone augmentation in the area (ie: continued bone loss, possible compromise of adjacent teeth and potential need for bone grafting in the future).

Please read carefully and ask your dentist if you have questions regarding any of the following:

1. I have been informed, and I understand the purpose, of the bone graft procedure.
2. I understand that there may be risks and complications of any procedure including swelling, bruising, pain, bleeding, infection, altered sensation (usually numbness at the donor site), allergic reaction or other adverse reactions to medications or materials used during or after the procedure.
3. I understand that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft; and that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.
4. It has been explained to me that, in rare instances, bone grafts fail and must be removed. Lack of adequate bone growth into the bone graft replacement material could result in failure. No assurances or guarantees as to the outcome of the results of treatment or surgery can be made. I am aware that should the bone graft surgery fail, it may require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. Should the bone graft surgery fail, I understand that alternative non-surgical prosthetic measures may have to be considered.
5. I understand that smoking or high blood sugar (diabetes) may effect gum healing and may limit the success of the bone graft. I agree to follow my doctor’s home care instructions. I agree to report to my doctor for regular examinations as instructed.
6. To my knowledge, I have given an accurate report of my health history. I have also reported any unusual reaction to drugs, anesthetics, food, insect bites, pollen or dust, any blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
7. I request and authorize medical/dental services for me, including bone grafts and other surgery. 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 of modifications in design, materials, or care, if it is felt this is for my best interest, including the decision not to proceed with the bone graft.

I have reviewed the above information, and have had the opportunity to have any questions/concerns addressed. Based on the information presented by my doctor(s) regarding my diagnosis, the proposed treatment, the treatment alternatives, and the associated risks and complications of such treatment, I request that you perform the planned surgical treatment.

Patient/Parent Signature____ **Date** ______________________________

Doctor/Assistant Signature____ **Date**______________________________