***"Mobile General Dentist
Providing Surgical and Implant Services"***

Consent for bone grafting procedure

Patient name: ______________________________ Graft Location:___________________________________

The purpose of the bone graft is to augment the bone deficiencies. A graft is required to have an adequate bone foundation to increase your success and prognosis. In addition to the risk of the primary surgical procedure which have been explained to me separately, I understand the bone grafting itself involve specific risks. My doctor has explained to me that such risks include, but are not limited to, the following:

GENERAL RISKS

1. Bleeding, swelling, infection, scarring, pain, numbness or altered sensation (possibly permanent) at the donor site, which may require further treatment.
2. Allergic or other adverse reactions to the drugs used during or after the procedure.
3. The need for additional or more expensive procedures in order to obtain sufficient bone.
4. Rejection of bone particles from surgical sites following surgery.
5. Rejection of the bone graft.
6. Rejection of the donated or artificial graft material.
7. The remote chance of viral or bacterial disease transmission from processed bone.
8. Additional bill may be required in adjunctive procedures based upon how your body adjust to the graph and healing resorption.

Further, as we age, we will lose bone as part of normal aging process and/or because of periodontal disease. As this occurs, the bone added in this procedure can be lost, and future procedures are required to treat this deficiency. It comes as a separate procedure and cost. If this continues to occur, osseous augmentation may be lost, and further procedures may be required to treat this deficiency.

CONSENT

I KNOWLEDGE THAT THE ABOVE HAS BEEN EXPLAINED TO MY SATISFACTION, AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THE RISK OF BONE GRAFTING. I AM FULLY AWARE THAT A PERFECT RESULT CANNOT BE GUARANTEED OR WARRANTED. MY SIGNATURE BELOW INDICATES MY UNDERSTANDING OF MY PROPOSED TREATMENT AND I HEREBY GIVE WILLING CONSENT TO THE SURGERY.

Patients or legal guardian signature Date

Doctor's Signature Date

Witnesses Signature Date

Office use only:

Materials used: (Initial by material used)

____________Cancellous/Cortical Bone Particulate

____________Non-Resorbable Membrane **____________Resorbable Membrane**

ANESTHESIA ORAL SURGERY IMPLANTOLOGY ENDODONTICS

P: 713-489.8338 E: Info@Jaredwdds.com W: Jaredwdds.com