BALACI
Oral and Facial Surgery

Consent for Sinus Elevation/Augmentation Surgery

You have the right to be given pertinent information about your proposed sinus elevation/augmentation surgery to make an informed decision about whether to proceed with surgery. What you are being asked to sign is a confirmation that we have discussed the nature of the proposed treatment, the known risks associated with it, and alternative treatment options.

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

Patient Name: ______________________________ Date: ______________ INITIAL HERE

1. The procedure necessary to treat the condition has been explained to me, and I understand the procedure to be ______________________________. ________

2. I hereby authorize Dr. ____________________ and any other agents, assistants, or employees selected by him to perform the above-stated procedure. ________

3. I understand incisions will be made inside my mouth in the back part of my upper jaw that will allow for a bony window to be outlined and very carefully repositioned with the elevation of the sinus membrane to allow for graft material to be placed. This procedure is being done to allow for eventual placement of root-form implants that will allow crowns or dentures to be placed. I acknowledge that the doctor has explained the procedure, including the location of the incisions and types of implants ultimately to be used. I understand that the crown, bridge, or denture will be made and attached to the implants later by Dr. ____________________, and a separate charge will be made for that work. ________

4. I understand that graft material must be in place for at least ______ months before it can be exposed for placement of the implant(s). I understand that a subsequent surgery will be required to uncover the top of the implant(s) that will be placed in this graft. ________

5. No guarantee can be or has been given that the graft will consolidate and thus be adequate for implant placement. It has also been explained that once implants are inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the sinus elevation and, consequently, the implant(s) may fail. ________

6. I have been informed of possible alternative methods of treatment (if any), which include ____. ________

7. I understand that other forms of treatment or no treatment are choices that I have, and the risks of those choices have been presented to me. ________

8. My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure, and in this specific instance, such risks include but are not limited to the following: ________

   A. Post-operative discomfort and swelling, which may require several days of at-home recuperation. ________

   B. Prolonged or heavy bleeding that may require additional treatment. ________

   C. Injury or damage to adjacent teeth or roots of adjacent teeth if present. ________

   D. Post-operative infection that may require additional treatment, including removal of the graft. ________

   E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly. ________

   F. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness or stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened. ________

   G. Injury to the nerve branches of the upper jaw resulting in numbness or tingling of the lower eyelid, side of the nose, and upper lip/cheek area, along with the gums on the operated site. This may persist for several weeks, months, or in rare instances, permanently. ________

   H. Some bleeding through the nostril on the side of the surgery may occur, which usually will last one to two days. ________

BALACI
Oral and Facial Surgery

Consent for Sinus Elevation/Augmentation Surgery

INITIAL HERE

I. I understand that if I am a smoker, I should not smoke one day before surgery, the day of surgery, and one day following surgery. ________

J. Swelling around the eye of the surgical side may even result in closing of the eye for a day or two. ________

K. Opening into the sinus after the surgery can occur and would require additional treatment. ________

L. Infection of the graft, possibly necessitating its total removal. The removal of the grafted bone from any donor has potential risks and complications, which also have been explained to me. ________

9. It has been explained that during this procedure, unforeseen conditions may be revealed, which may necessitate an extension of the original procedure from those outlined in statement 1 above. In rare cases, it may not be possible to continue with the procedure. Therefore, I authorize my doctor to perform such procedures as are necessary and desirable in the exercise of professional judgment. In rare cases, it may not be possible to continue with the procedure. ________

10. I consent to the administration of ____________________ anesthesia in connection with the procedure referred to above. If intravenous anesthesia is used, there may be soreness at the injection site or along the vein, as well as some bruising around the injection site. In rare cases, the vein irritation may cause restricted mobility of the arm or hand and may require additional treatment. ________

11. I have been made aware that certain medications, anesthetics, and prescriptions I may be given can cause drowsiness, lack of awareness, and affect my coordination, which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications or until fully recovered from the effects of the same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of the medication. If I am to be given a sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of sedation. ________

12. I understand that if I am receiving general anesthesia, I must not eat or drink anything for at least eight hours before my surgery. To do otherwise may be life-threatening, and my surgery will be canceled. ________

13. It has been explained and I understand that a perfect result is not and cannot be guaranteed. ________

14. I authorize photos, slides, X-rays, or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. However, my identity will not be revealed to the general public without my permission. ________

15. I fully understand this consent for surgery, and I certify that all blanks were filled in before signing this form. ________

Please ask your doctor if you have any questions concerning this consent form.

Patient's (or Legal Guardian's) Signature: ________________________________ Date: ____________

Doctor's Signature: ________________________________ Date: ____________

Witness' Signature: ________________________________ Date: ____________