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**CONSENT FOR SINUS AUGMENTATION BONE REGENERATIVE SURGERY**

Please review the following consent form. You are required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

**Diagnosis:**  After a careful examination and study of my dental condition, I have been advised that I have sinus pneumatization (expanding sinus). I hereby authorize Dr. Barry Kaplan and Dr. Scott Ganz to treat this condition.

**Recommended treatment:** In order to treat this condition, it has been recommended that my treatment include bone regenerative (sinus augmentation) surgery. Local anesthetic will be administered to me as part of the treatment. Antibiotics and other medications will be given.

During this procedure, the gums will be opened to permit better access to the eroded bone. Bone irregularities may be reshaped with a dental drill. Some bone will be removed to create a window to access the maxillary sinus. Bone graft material will be placed in the areas of bone loss in the floor of the maxillary sinus. Various types of graft materials may be used. These materials may include my own bone, animal bone material (cow or pig) or bone obtained from tissue banks (human donors). Collagen wafer membranes made from Achilles tendons of animals (cow or pig) will be used, depending on the type of bone defect present. Membranes tend to hold the bone graft material in place while it heals. My gum will be sutured back into position over the above materials.

I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to termination of the procedure prior to completion of all of the surgery originally outlined.

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**Expected Benefits:** The purpose of sinus augmentation bone regeneration surgery is to “grow” bone.

**Principal Risks and complications:** I understand that complications may result from surgery and/or any drugs used. These complications may include, but are not limited to the following:

1. Swelling, pain, temporary discoloration of my face.
2. Prolonged or heavy bleeding that may require additional treatment.
3. Postoperative infection that may require additional treatment including removal of the graft.
4. Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.
5. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened.
6. Nerve damage can occur and infections can spread to other parts of the body.
7. Nose bleeds can occur and local infection can spread to the bone (osteomyelitis).
8. Failure of the bone graft can occur.
9. Chronic or acute sinusitis may occur as a result of this procedure.
10. Existing sinusitis may be aggravated or recur more frequently. Complications may be irreversible.
11. Injury to the nerve branches of the upper jaw resulting in numbness or tingling of the lower eyelid, side of the nose and lip, teeth, gum or cheek area. This may persist for several weeks, months, or in rare instances, permanently.
12. Some bleeding through the nostril on the side of the surgery may occur which usually will last one to two days.
13. Swelling around the eye of the surgical side may even result in closing of the eye for a day or two.
14. Opening into the sinus after surgery can occur and would require additional treatment.
15. Infection of the graft, possibly necessitating its total removal. The removal of grafted bone from any donor site has its own potential risks and

complications, which have been explained to me.

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Complications may be irreversible

There may be a need for a second procedure if the initial results are not satisfactory. The success of sinus elevation procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to Dr. Kaplan any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

**Alternatives to Suggested Treatment:** Alternatives to the sinus augmentation bone regenerative surgery include:

1. No treatment, resulting in the patient only being able to wear either an upper or a lower partial
2. No teeth replacement.

I have told Dr. Kaplan about any pertinent medical conditions I have, known allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Kaplan about any present or prior head and neck radiation therapy.

I have told Dr. Kaplan about any present or prior use of bisphosphonate medications. Some common brand names are Zometa, Aredia, Boniva, Fosamax, and Actonel.

I need to come back for several post-operative checkups so that healing may be monitored and so Dr. Kaplan can evaluate the outcome of surgery. It may be necessary to remove both non-resorbable sutures and non-resorbable membranes used in the sinus augmentation bone regeneration surgery.

I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr. Kaplan for post-operative check-ups as needed.
3. Not smoke or use smokeless tobacco as noted above.
4. Avoid water-piks for at least one month.
5. Have any non-dissolvable sutures (stitches) and membranes removed.

1. Get the tooth/teeth replaced as recommended.
2. Initials\_\_\_\_\_\_\_\_\_\_\_\_

**No Warranty or Guarantee:** While in most cases bone regenerative surgery heals quickly and without any problems, complications such as those listed previously, can happen despite the best of care. I understand that I will be responsible fees relating to any and all complications that may develop.

**Publication of Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry, in written or internet publications or sites, and in promotional materials. My identity will not be revealed to the general public.

**Communication with my insurance company, dentist or other dental/medical providers:** I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during or after its completion with my insurance carriers, my dentist, and any other health care provider I may have who may need to know about my dental treatment.

**Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

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**Informed consent for sinus augmentation bone regenerative surgery:**

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this sinus augmentation bone regenerative surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling Dr. Kaplan of any pertinent medical conditions and prescription and non-prescription medications. I have had an opportunity to ask questions and have received answers to my satisfaction. I also understand that any questions that I might have during treatment will be answered when I ask them. I voluntarily assume any and all possible risk of substantial harm, if any, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service has been explained to me and is satisfactory. I understand that I will be responsible for fees relating to any and all complication that may develop. By signing this form, I am freely giving my consent to the performance of the sinus augmentation bone regenerative surgery as presented to me during my consultation and as described in this document above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Kaplan and Dr. Ganz. I have read and understood this document before I signedit. I authorize Dr. Barry Kaplan and Dr. Scott Ganz and whomever they may choose as their assistants to perform the proposed sinus augmentation bone regenerative surgery.

\_\_\_\_I give my consent for the proposed procedures as described above.

\_\_\_\_I refuse to give my consent for the proposed procedures as described above. I have been informed of the potential consequences of my decision to refuse this treatment.

Patient Name:

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Patient’s Signature Date