Bone Graft Consent

This is my consent for Dr. _____ to perform the following

Procedure _____for Name: _____.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

*My dentist has explained forms of treatment. I have chosen the bone graft to provide stability for future treatment.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible.

I am aware that each patient heals in a different manner after bone graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

I understand that smoking, drinking alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and have my bone graft checked as well as have regular checkups and hygiene.

To my knowledge, I have given the proper medical information in regards to my physical and mental states (medications, diseases, syndromes, etc). I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin , any abnormal bleeding, or any condition related to my overall health.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____