NORTH BETHESDA PERIODONTAL GROUP

KHALID CHOUDHARY, DDS, MS ◊ JOAN HOWANITZ, DDS MS

DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

Bone Grafting and Barrier Membrane Consent Form

Patient Name: _____ Date: _____

I understand that bone gatfing and barrier membrane procedures include inherent risks such as but not limited to the following:

1. **Pain**. Some discomfort is inherent in any oral surgery procedure. Grafting with materials that do not have to be harvested from your body are less painful because they do not require a donor site surgery. If the necessary bone is taken from any other area of your mouth (i.e., your chin, wisdom tooth area in the back of your mouth) there will be more pain. It can be largely controlled with pain medications.
1. **Infection**. No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.
2. **Bleeding, bruising, and swelling.** Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.
3. **Loss of all or part of the graft.** Success with bone and membrane grafting is high. Nevertheless, it is possible that the graft could fail. A block bone graft taken from somewhere else in your mouth may not adhere or could become infected. Despite meticulous surgery, particulate bone graft material can migrate out of the surgery site and be lost. A membrane graft could start to dislodge, If so, the doctor should he notified. Your compliance is essential to assure success.
4. **Types of graft material.** Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by different means to be free from contaminants. Signing this consent form gives your approval for the doctor to use such materials according to his/her knowledge and clinical judgment for your situation.
5. **Injury to nerves.** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur, may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
6. **Sinus involvement**. In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus. Occasionally, with extractions and/or grafting near the sinus, the sinus can become involved. If this happens, you will need to take special medications. Should sinus penetration occur, it maybe necessary to later have the sinus surgically closed.
7. It is your responsibility to seek attention should any undue circumstances occur post-operatively and you should diligently follow any pre-operative and post-operative instructions.

Informed Consent: As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize *Dr. Khalid Choudhary & Dr. Joan Howanitz* to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.**:** I understand that no guarantee as to results (functional, aesthetic, or otherwise) can be or has been promised. I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____