

McManigal Family Dentistry  
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## **BONE GRAFT CONSENT FORM**

1. I have been informed and I understand the purpose and the nature of the bone graft surgery procedure. I understand it is being done to enhance the healing shape of my bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire a bone graft to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are Inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capacities in each patient following the placement of the bone graft.
6. It has been explained that in some instances bone grafts fail and must be removed, I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.
7. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the graft. I agree to follow my doctors home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_