PERIODONTAL & IMPLANT SURGEONS OF GREENVILLE
PATRICK L. JOHNSON, D.D.S
PRESTON S. ALFRED, D.D.S.,M.S.

CONSENT FOR SINUS AUGMENTATION PROCEDURE

Recommended Treatment: In order to treat my condition, my periodontist has recommended that my treatment include a sinus augmentation procedure. During this procedure, my gum will be opened to permit access to the sinus Graft material will be placed in the sinus that may include synthetic or tissue bank bone. My gum will then be sutured back into position.

Expected Benefits: The purpose of bone regenerative surgery is to add bone to the sinus in anticipation of implant placement.

Principal Risks & Complications: I understand that complications may result from the periodontal surgery involving bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanently increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. In the event that donated tissue is used in the graft, the tissue has been tested for infectious diseases. Nevertheless, there is a remote possibility that tests will not determine the presence of diseases in a particular donor tissue.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not entirely successful. In addition, the success of bone regenerative procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures – depending on the circumstances. However, continued wearing of ill-fitting appliances can result in further damage to the bone and soft tissue of my mouth.

I have been fully informed of the nature of sinus augmentation surgery, the procedure to be utilized, the risks and benefits of surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with the periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Printed Name of Patient or Parent/Guardian	Signature of Patient or Parent/Guardian	Date

Printed Name of Witness	Signature of Witness	Date