deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR TOOTH EXTRACTION / RIDGE PRESERVATION

Name: _____ Date: _____ Tooth: _____

Upper Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Upper Left
Lower Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower Left

EXPLANATION OF DIAGNOSIS: I have been informed of the need for a dental extraction (the removal of a tooth or several teeth). The reasons for this extraction could be irreparable tooth decay, cracked or broken teeth, a re-infected root canal, or advanced gum disease resulting in bone loss. I have been informed that simultaneous bone augmentation is recommended in areas of my jaw where I will be having teeth removed to support dental implants and conventional dental prosthetics.

RECOMMENDED TREATMENT: After anesthetics have numbed the surgical area, the gum is reflected from the jaw bone surface, teeth are removed, extraction sites are cleansed of any infected tissue, and graft material placed into the extraction sockets and on bone surfaces. A guided tissue barrier membrane may then be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration, and to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth and/or together.

EXPECTED BENEFITS: The purpose of a ridge preservation and bone replacement graft is for the graft material to act as scaffold that will be replaced by your own new bone, thus creating a secure location for an implant.

GRAFT MATERIAL: Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by various means to be free from contaminants. This signed consent form acknowledges your approval for the doctor to use such materials according to his/her knowledge and clinical judgment for your situation.

ALTERNATIVES TO THE PROCEDURE: Alternatives may include: (1) No treatment, and the expectation that my condition will advance and result in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic result. (2) Building up the ridge with soft tissue grafts, which would not increase the possibility of using dental implants. (3) Extending the depth of the cheek pouch by surgery with or without the use of a soft tissue graft, which would not increase the possibility of using dental implants or improve the aesthetics or phonetics related to design of a fixed bridge.

PRINCIPLE RISKS AND COMPLICATIONS: Risks related to surgery with extraction and ridge bony regeneration by the use of bone grafts may include, but are not limited to: fracture of the tooth/teeth during extraction, retention of part of a root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient or possibly permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, transient or possibly permanently increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, or shrinkage of the gum upon healing (with possible elongation of and/or greater spaces between some teeth). Risks related to anesthetic might include but are not limited to allergic reactions,

Initials: _____

accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness, or discoloration at the site of the anesthetic injection.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infections, or further bone loss or gum recession. It is anticipated that surgery will provide benefit in reducing the cause of this condition and produce healing that will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, even with the best of care, there exists the risk of failure, relapse, the need for additional treatment, or worsening of my present condition that includes the possible loss of certain teeth due to advanced involvement.

CONSENT TO UNFORSEEN CONDITIONS: Unforeseen conditions may be discovered during surgery that call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of the surgical plan originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that **smoking and/or alcohol intake may affect gum healing and may adversely affect the successful outcome of my surgery**. I agree to follow instructions related to my own daily care of my mouth and to the use of prescribed medications. I agree to report for appointments following my surgery as suggested so my healing may be monitored, and the doctor may evaluate and report the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all, procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Signature of Patient or Parent/Guardian	Date
Printed Name of Patient	Relationship to Patient
Signature of Witness	Date