INFORMED CONSENT FOR
RIDGE AUGMENTATION SURGERY

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DDS | MS

DIAGNOSIS After a careful oral examination and study of my dental condition, Dr. Williamson has recommended a ridge augmentation and/or preservation procedure. I understand that a ridge augmentation procedure is designed to restore bone and/or gum tissue that has been lost as a result of a tooth extraction or trauma. I also understand that a ridge preservation procedure is performed to minimize the amount of bone and gum tissue resorption that results from the extraction of a tooth.

RECOMMENDED TREATMENT Dr. Williamson has recommended using a combination of treatments to accomplish the ridge augmentation/preservation procedures. These treatments include but are not limited to: transplanting gum tissue from the roof of my mouth, using a bone graft obtained from either a commercial bone bank or from bone obtained from my own mouth and the use of regeneration membranes that may dissolve on their own or have to be removed by Dr. Williamson at a later time.

EXPECTED BENEFITS The purpose of this procedure is to help maintain or recreate a bone and/or gum tissue profile that mimics as naturally as possible the jaw prior to extraction of the teeth. I understand that there are limitations to how much this procedure can accomplish and that the final result, in many cases will be a compromise of what appeared prior to the loss of the tooth.

PRINCIPAL RISKS AND COMPLICATIONS I understand that a small number of patients do not respond successfully to ridge augmentation/preservation procedures. These procedures may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the periodontal surgery, 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 permanent 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. The exact duration of any complications cannot be determined, and they may be irreversible. 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 results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene and medications that I may be taking. To my knowledge, I have reported to Dr. Williamson any prior drug reactions, allergies, diseases, symptoms, habits, 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 Dr. Williamson and taking all prescribed medications are important to the ultimate success of the procedure. **I will inform my dentist if I am taking or have taken bisphosphonate drugs in the past. I understand that if I am taking oral bisphosphonates, several complications can occur after having this type of procedure and I have discussed it with my dentist.**

ALTERNATIVES TO SUGGESTED TREATMENT I understand that alternatives to the recommended treatment include no treatment or using alternative techniques and materials. These alternatives have been discussed to my satisfaction.

NECESSARY FOLLOW-UP AND SELF-CARE I understand that following post-operative instructions and following Dr. Williamson's recall recommendations are important to assure optimal healing results. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

NO WARRANTY OR GUARANTEE I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences; however, a doctor cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

PUBLICATION OF RECORDS I authorize photos, including those of my face, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry or for reimbursement purposes. My name, however, will not be revealed to the general public without my permssion.

CONSENT FOR SEDATION Because medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can increase with the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least 24 hours or longer until recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any major decisions until after recovery from anesthesia and will have a responsible adult accompany me until I am fully recovered. I have been informed to not drink alcohol or take other nervous system depressants for 24 hours following medication administration. I understand that anesthetics, medications,

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and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Michael Williamson of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the procedure. For the same reason I understand that I must inform Dr. Michael Williamson if I am a nursing mother. I have been fully advised of and completely understand the alternatives to sedation and accept the possible risks and dangers. I acknowledge the receipt of and understand the preoperative instructions given to me. It has been explained to me and I understand that there is no warranty of guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and am satisfied with the information provided to me. I acknowledge that the options for sedation including local anesthesia and conscious sedation have been explained to me. I consent, authorize and request the administration of such anesthetics. I have been made aware of the potential complications associated with the sedation including but not limited to nausea, vomiting, allergic reaction, fluctuations in breathing patterns, heart rhythm and or blood pressure; brain damage and even death. I authorize any corollary procedure, including hospitalization that is necessary to manage my case.

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal 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 Dr. Williamson. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the doctor. I authorize that my treatment and/or financial information may be discussed with family members, guardians, or accompanying chaperones.

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

SIGNATURE of patient, parent, or guardian

Date

SIGNATURE of witness

Date