INFORMED CONSENT FOR
SINUS ELEVATION / AUGMENTATION SURGERY

MIKE WILLIAMSON
DDS | MS

You have the right to be given pertinent information about your proposed implant placement so that you have sufficient information to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is a confirmation that we have discussed the nature of the proposed treatment, the known risks associated with it and the feasible alternate treatments.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK DR. WILLIAMSON BEFORE SIGNING THE CONSENT FORM.

PATIENT.. DATE....................................

I hereby authorize Dr. Williamson, and any other agents, assistants or employees selected by him to perform a sinus elevation/augmentation procedure and I understand the nature of the procedure.

I understand incisions will be made inside my mouth in the back part of my upper jaw that will allow for a bony window to be outlined and then very carefully repositioned with elevation of the sinus membrane to allow for graft material to be placed. This procedure is being done to allow for ultimate placement of root form implants that will allow crowns or dentures to be placed ultimately. I acknowledge that the doctor has explained the procedure, including the location of the incisions and types of implants ultimately to be used. I understand that the crown, bridge or denture that will later be attached to these implants will be made and attached by my restorative dentist and that a separate charge will be made for that work. I understand that the graft material may need to be in place for 3-8 months before it can be exposed for placement of implants. I understand that a subsequent surgery may be required to uncover the top of the implants that will be placed in this graft. No guarantee can be or has been given that the graft will consolidate and thus be adequate for implant placement. It has also been explained to me that once implants are inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implants and even grafts may fail. The source of bone grafting material has been explained to my satisfaction.

Dr. Williamson has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance, such risks include, but are not limited to, the following:

- Post-op discomfort and swelling that may require several days of at-home recuperation
- Prolonged or heavy bleeding that may require additional treatment
- Injury or damage to adjacent teeth or roots of adjacent teeth if present
- Post-op infection that may require additional treatment including removal of the graft
- Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly
- Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ)
- Pre-existing TMJ symptoms may be worsened
- Injury to the nerve branches of the upper jaw resulting in the numbness or tingling of the lower eyelid, side of the nose and upper lip/cheek area along with the gums on the operated side. This may persist for several weeks, months, or in rare instances, permanently.
- Some bleeding through the nostril on the side of the surgery may occur which usually will last one to two days
- Swelling around the eye of the surgical side may even result in closing of the eye for a day or two
- Opening into the sinus after surgery can occur and would require additional treatment
- Infection of the graft, possibly necessitating its total removal. The removal of grafted bone from any donor site has its own potential risks and complications, which also have been explained to me.

It has been explained to me that during the course of this procedure, unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from those set forth above. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such different procedures(s) as necessary and desirable in the exercise of professional judgement. **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.**

I give my consent to the administration of anesthesia in connection with the procedure referred to above. If intravenous anesthesia is used, there may be soreness at the injection site or along the vein as well as some bruising around the injection site. In rare cases, the vein irritation may cause restricted mobility of the arm or hand and may require additional treatment.

CONTINUED

I have been made aware that certain medications, drugs, anesthetics and prescriptions which I may be given can cause drowsiness, incoordination, and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.

I understand that I am not to have **ANYTHING** by mouth for at least six hours before my surgery. **To do otherwise may be life threatening.**

I understand that if I am a smoker, I should not smoke the day before surgery, the day of surgery, or the day after surgery.

It has been explained to me, and I understand, that a perfect result is not, and cannot be guaranteed or warranted.

I certify that I speak, read and write English and have read and fully understand this consent for surgery.

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.

I authorize that my treatment and/or financial information may be discussed with family members, guardians, or accompanying chaperones.

PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

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

SIGNATURE of patient, parent, or guardian .... Date ....

SIGNATURE of witness .... Date ....