Menlo Park Dental Excellence-ChauLong T Nguyen Dental Corporation
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Discussion and Informed Consent for Bone Grafting and/or Regeneration

Patient Name: _____**Date**:_____

Diagnosis: Dr. Nguyen's Initial required:
___Severe cavity to bone and furcation of tooth #_____
___Root fracture causing abscess/infection and bone loss of tooth #_____
___Acquired missing teeth with severe bone loss and resorption in tooth #s_____
___Severe pneumatization of maxillary sinus due to missing teeth in extended time in tooth#_____
___Severe vertical, angular bone loss and localized moderate to severe periodontitis in tooth#_____

Treatment:

1. Scale and Root Planning for teeth #s_____
2. Extraction of tooth # _____
3. Use BioMend/Bio-Gide Membrane as collagen resorbable membrane for tooth # _____
4. Use Puros, Bio-oss Particulate bone graft for tooth #_____
5. Use autogenous connective tissue graft on surfaces of tooth #_____

FACTS FOR CONSIDERATION - *Patient's Initials Required*

_____I have been informed that I have periodontal (gum and bone) problems and/or disease that should be surgically treated, including the use of bone grafting and techniques for bone regeneration. I understand that the purpose of this procedure in conjunction with periodontal (gum) flap surgery is to allow access for the removal of bacteria by cleaning the roots of teeth and the lining of the gum. It also may treat irregularities, if any, of the jawbone by the use of bone graft material so when the gum is replaced about the teeth, it will allow the reduction of gum pockets, infection and inflammation and may improve bone healing. The decrease in gum pocket depths may improve the ease and effectiveness of my personal oral hygiene and the ability of a dental professional to better clean my teeth. The decrease in infection and inflammation may minimize further loss of bone and gum tissue supporting my teeth which may aid in longer retention of my teeth in the operated area(s).
_____After anesthetics (numbing medication) are applied by injection and have numbed the area to be operated on, the gum is reflected (incised at surgery) to expose

the roots of the teeth which are then cleaned and smoothed. Antibiotics and/or other chemicals may be applied to the roots to decontaminate them before the graft material is placed in the area(s). There may be additional charges for topical antibiotics.

_____I have been advised that bone grafting may be performed in areas of my mouth associated with gum pocketing and/or recession. It has also been explained to me that this is a procedure that may involve surgical grafting of bone by removing a piece(s) of bone from another area of my body, requiring another surgical site, or using commercially made bone graft from another human or animal bone source. The graft material may be used in a block form over a large area or in particulate form for smaller areas. I acknowledge that I have had an opportunity to discuss these options, and my choice, with my dentist before consenting to this treatment, procedure or surgery.

***You must acknowledge and initial one but not both of the next two paragraphs:**

_____By initialing this paragraph, I acknowledge and state that I do not have any objection to the source or origin of the bone graft material whether it be human or animal.

OR

_____By initialing this paragraph and its parts I am stating my objection to the origin of the bone graft material that may be used: No human ( ), No Animal ( )

Benefits of Bone Grafting and/or Regenerative Surgery, Not Limited to the Following:

_____The goal of bone grafting and or regenerative surgery is to assist or help “grow” bone back (for the longevity of the tooth), or to possibly allow for dental implant placement either at the same time as this surgery or a later date. Additionally, the purpose of this surgery may be to help build a restorable jaw ridge for better esthetics and function where a replacement (artificial) tooth will go as part of a dental bridge.

Risks of Bone Grafting and/or Regenerative Surgery, Not Limited to the Following:

_____I understand that with surgery there may be postoperative bleeding, swelling, pain, infection, facial discoloration, temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweets, or acidic foods. A temporary or permanent numbing of the surgical areas may occur affecting my lips, chin and tongue, possibly affecting my sense of taste. I understand that I may see changes in the appearance of my gums. They may be in a different position on the roots or there may be spaces between the teeth that are larger. I understand that my teeth may appear “longer” and my roots may be exposed. I also understand that there may be a need for a second procedure if the initial surgery is not entirely successful.

_____I understand that I will receive a local anesthetic by injection and/or other medication(s). In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect my ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury resulting in loss of feeling of the chin, lips, gums, tongue and partial loss of taste can result from an injection.

_____I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____I understand that all medications have the potential for accompanying risks, side effects, and drug interactions.Therefore, it is critical that I tell my dentist of all medications, and supplements that I am currently taking, which are:_____
_____

_____I understand that smoking and/or chewing tobacco and/or alcohol intake may affect my ability to have normal gum and/or bone healing and may limit the potential for a successful outcome of my surgery. Smoking may adversely affect the extraction site healing and may cause “dry socket” (an infection of the bone of the socket walls). Smokers are at higher risk for “dry socket” and have more dry sockets than non-smokers. I agree to follow my dentist’s instructions related to daily care of my mouth, teeth and gums.

Alternatives to Suggested Treatment:

_____I understand that alternatives to bone graft and/or regenerative surgery include no treatment, non-surgical scraping of the teeth roots and lining of the gum (scaling and root planning), with or without medication, in an attempt to further reduce bacteria and tartar under the gumline, dental bridgework, removable partial dentures and no teeth replacement.

Alternatives discussed:

1. ___Seek a second opinion from a periodontist, endodontist, oral surgeon, nutritionist
2. ___Scale root planning with laser curettage and frequent dental cleaning maintenance
3. ___Extraction
4. ___bone graft, implant, abutment, crown, or removable partial denture, dental bridgework

5. ___Doing nothing will cause severe infection that may cause blindness, difficulty swallowing, breathing, or even death and or bone and tooth loss to adjacent teeth and this affected tooth or bone.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check only one of the boxes below that applies to you:

CONSENT

- ❏ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

OR

REFUSAL

- ❏ I refuse to give my consent for the proposed treatment as described above and understand the potential consequences associated with this refusal.

_____ _____

Patient's (Patient Representative) Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to bone and gingival grafting with Mr., Mrs., Ms., _____ who has had the opportunity to ask questions, and I believe my patient understand what has been explained and willingly consents to the treatments noted herein. As part of this consent agreement, I give my personal pledge as a healthcare professional dedicated to the well-being of my patient to make every reasonable effort to assure the patient receives the best possible care with the least possible risk.

Dr. ChauLong Nguyen, DDS, MAGD _____Date:_____

Witness (Staff) Signature:_____Date:_____