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ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION AND INFORMED CONSENT
INTERNAL SINUS MEMBRANE LIFT AND BONE GRAFT PROCEDURE

PURPOSE OF SINUS AUGMENTATION SURGERY: I am aware that I do not have enough bone to anchor dental implants in the rear areas of my upper jaw where there are teeth missing. I have been informed that the purpose of this procedure is to raise the floor of the maxillary sinus through the inside of the bone and gain additional height in the bone. This is to provide adequate bone for the anchorage of dental implants, which in turn will provide a foundation for dental prosthetic tooth replacement of teeth missing in my upper jaw.

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw surface a small hole will be drilled into the bone for the purpose of placing one or more metallic implants. This will be done lower than the level of the existing sinus. After this a small dental mallet will be used to sequentially tap the bone with specialized instruments and the sinus floor will be gently pushed upwards making room for the implant of adequate height to be placed. After the implant is placed, the gum is repositioned to cover the jaw and is sutured back into place to close this wound.

DESCRIPTION OF THE GRAFT MATERIAL IF NEEDED: Sometimes, supplemental bone grafting procedure may be necessary during placement of the dental implant. This supplemental bone is placed in the form of bone particles obtained from the patient's jaw at sites around the implant site or by the use of exogenous sources in accordance with usual practices. They include either purified bovine bone or purified demineralized freeze-dried bone from a tissue bank. The alternative to these is synthetic bone containing calcium phosphate particles. The purpose of these materials is to stimulate the formation of new bone and gets incorporated into the new bone and cannot be removed. The barrier membrane is made from purified collagen usually derived from bovine sources. I give consent for my doctor to use either of these materials using the best clinical judgment. I will indicate any objections about using any of the exogenous bone sources at the bottom of the form.

RISKS RELATED TO THE PROCEDURE: It is understood that although good results are expected no guarantee that it will last for any specific period of time can be or has been given. My doctor has explained to me that the rear areas of the upper jaw have a lower rate of success rate compared to other areas of the human jaw, due to the inherent quality of the bone. I have been informed and understand that occasionally there are complications of surgery, drugs and anesthesia, including, but not limited to: 1. Pain, swelling and postoperative discoloration of face, neck and mouth. 2. Numbness and tingling of the upper lip, chin, gums, teeth check and palate, which may be transient, but may be permanent. 3. Infection of the bone that might require further treatment, including hospitalization and surgery. 4. Malunion, delayed union or non-union of the synthetic bone replacement material to normal bone, or lack of adequate bone growth into the synthetic material. 5. Bleeding which may require blood transfusions or other extraordinary means to control. 6. Limitation of jaw function. 7. Stiffness of facial and jaw muscles. 8. Injury to the teeth. 9. Referred pain to the ear, neck and head. 10. Postoperative complications involving the sinuses, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the upper cheek and eyes. 11. Postoperative unfavorable reactions to drugs, such as nausea, vomiting and allergy. 12. Possible loss of teeth and bone segments. 13. Possible bruising and/or discoloration of the face, usually of a temporary nature. 14. Perforation of the sinus membrane causing an opening from the oral cavity into the nasal cavity, requiring an additional surgical procedure to close it and inability to place the dental implant during the procedure or future. Additional risks related to any oral surgical procedure that includes administration of local anesthetics, also applies to this procedure and includes: Injury to the nerves of the lips, the tongue, the tissues in the floor of the mouth, and/or the cheeks, etc. These possible nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue which may be of a temporary nature lasting a few days, a few weeks, a few months, or could possibly be permanent. The alteration or loss of sensation, numbness, pain, or altered feeling may occur in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent. Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials.

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ALTERNATIVES TO THE PROCEDURE: I am aware that this is an elective procedure and I have been informed of the alternatives to an osseointegrated implant. These may include: (1) no replacement of missing upper teeth; (2) construction of a standard dental prosthesis (bridge, partial denture or complete denture depending on the clinical situation); (3) continued advancement of bone loss in the area of missing upper back teeth with possible future erosion into the sinus, i.e., the formation of a hole between the mouth and sinus which could lead to the development of chronic infection in the sinus.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will provide enough bone for dental implant anchorage. It is anticipated that the surgery will provide benefit in producing some bone, but it cannot be reasonably predicted so as to guarantee the nature of the eventual prosthetic solution, i.e., fixed versus removable tooth replacement. Due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, despite the best of care.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth, to the use of prescribed medications and to the limitations in use of current removable partial or full dentures. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of the surgery. I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records which identify me will be used without my express written consent.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to, inability to place the dental implant, sinus perforation or termination of the procedure prior to completion of all of the surgery 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.

INFORMED CONSENT

I have been given the opportunity to ask any questions regarding the nature and purpose of INTERNAL SINUS LIFT AND BONE GRAFT procedure and have received answers to my satisfaction. I have also been given the option of seeking care from an oral and maxillofacial surgeon. My doctor has discussed with me about the advantages, disadvantages, alternative options, risks, sequence and cost of my treatment options. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize **DR. SAMUEL LEE** and/or his/her associates to render treatment pertaining to Implant Surgery procedures considered necessary and/or advisable to my dental conditions, including the prescribing and administering of any medications and/or anesthetics deemed necessary for my treatment.

I object to the use of exogenous bone graft- INDICATE THE TYPE, IF ANY, OBJECTION HERE:

SIGNATURE OF PATIENT **DATE**

I certify that the matters set forth above were explained fully to the patient, that the patient was given an opportunity to ask questions, that all questions asked were answered in a satisfactory manner, and that all the blanks in this form were filled in prior to signature by the patient. Where this form has been signed by the patient rather than his/her representative, I certify that, in my judgement, the patient was competent to understand the matters discussed and to give his/her consent to treatment.

SIGNATURE OF DENTAL SURGEON **DATE**