Bichara
Periodontics & Dental Implants

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CONSENT FOR BANKED BONE GRAFT

I hereby authorize and request Dr. Bichara to perform corrective surgery on my jaw (maxilla or mandible). The operation is planned to implant bone graft material processed from a tissue bank, onto my jaw in the hope that new bone will be incorporated into the material so that an implant(s) might be placed. A second procedure might be needed to place the implants(s). It is hoped that the implants will become stable and act as anchors for fixed or fixed detachable bridges or dentures. Dr. Bichara has explained that if the new bone does not incorporate into the graft material that alternative prosthetic measures will have to be considered.

Dr. Bichara has explained and described the operation to my satisfaction. It is understood that although good results are expected, no guarantee that it will last for any specific period time can be or has been given.

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, cheek and palate, which may be transient but may be permanent.
3. Infection of the bone that may require further treatment, including hospitalization and surgery.
4. Malunion, delayed union or non-union of the bone replacement material to normal bone or lack of adequate bone growth into the 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 reaction to drugs, such as nausea, vomiting and allergy.
12. Possible loss of teeth and bone segments.

I further understand that I am to refrain from the use of alcohol, smoking or non-prescribed drugs during the treatment period. If sedation is used, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until recovered from the effects of the drugs given for my care.

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to the individual patient differences, there exists a risk of failure, relapse, selective re-treatment or worsening of my present condition despite the best care. However, it is Dr. Bichara's opinion that therapy will be helpful, and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance visits (recall professional care).

I consent to photographs of my oral and facial structures and their publications for educational and scientific purposes.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT AND THE EXPLANATIONS REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

_____	_____
Print Patient Name	Date
_____	_____
Patient Signature (Parent or Guardian)	Date
_____	_____
Witness Signature	Date
_____	_____
Doctor Signature	Date