Paul D'Aoust Dentistry Professional Corporation
732 Arlington Park Place
Kingston ON K7M8H9

(613)634-6221

www.kingstonperio.com

CONSENT FOR ORAL SURGERY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Diagnosis: Sinus Lift
After a careful oral examination, Dr. D'Aoust has advised me that I have a condition that requires bone grafting to prepare an area for implant placement.

Recommended Treatment:
In order to treat my condition, Dr. D'Aoust has recommended the use of processed bone of animal or human origin, or that bone is taken from an area of my mouth and used to augment the floor of the sinus. I understand that a local anesthetic will be administered to me as part of the treatment and sedation may be utilized.

Expected Benefits:
The purpose of the procedure is to replace missing bone so that an implant can be placed in this location.

Alternatives to Suggested Treatment:
I understand that alternatives to this procedure include: no treatment, a removable complete or partial denture, and a bridge. However continued wearing of ill-fitting appliances can result in further damage to the bone and soft tissue of the mouth.

Nose Blowing:
I understand that any processes that increase the pressure within the sinus cavity (nose blowing, sneezing, oral inflation of balloons) must be avoided for a minimum of 14 days after the surgery.

Primary Risks and Complications:
I understand that a small number of patients do not respond successfully to surgery, and in such cases, the involved teeth may eventually be lost. Because each patients condition is unique, long-term success may not occur.I understand that complications may result from the surgery, drugs, and anesthetics. These complications include, but are not limited to:

- Bleeding, swelling and pain
- Allergic reactions
- Post-sugical infections
- Impact on speech
- Facial discolouration (bruise)
- Accidental swallowing of foreign objects
- Transient or permanent numbmess of the lip, tongue, teeth, chin or gum
- Transient or premanent tooth sensitivity to hot, cold, sweet or acidic foods
- Delayed healing
- Jaw joint injuries or muscle spasms
- Cracking or bruising of the corners of the mouth; breakout of cold sores
- Restricted ability to open mouth for several days or weeks
- Worsening of the condition
- Transient or permanent tooth looseness
- Fracture of adjasent restorations or teeth
- Exposure of crown margins on teeth with crowns/bridges/veneers

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I understand that if I smoke, I have more risk for the above complications. The exact duration of any complication(s) 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 my surgeon any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which may in any way relate to this surgical procedure.

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. Due to individual patient differences, a therapist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants, despite the best care.

Sedation:
I understand that if I take oral or IV sedation, I will need a driver to and from my appointment and that I should not operate any heavy equipment/machinery for 24 hours following the use of sedation.

Patient Consent:
I have been fully informed of the nature of the required extraction or oral surgery, the risks and benefits, the alternative treatments available, and the necessity for follow-up care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my surgeon. After thorough deliberation, I hereby consent to the performance of extraction or oral surgery as presented to me during consultation and in the treatment plan presented to me. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my surgeon. I understand that these additional or alternative procedures may involve added cost that may not have been outlined in the estimate of treatment costs.

MEDICATION: PLEASE START ALL PRESCRIBED MEDICATION ONE DAY PRIOR TO YOUR SURGICAL APPOINTMENT

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Signature: _____ Date: _____

Response Date: _____