3900 Fifth Ave, Suite 270, San Diego, CA 92103
(619)-810-1864

SINUS AUGMENTATION CONSENT FORM

Patient Name: _____ **Date:** _____
Treatment Area: _____
Alternatives:

- No treatment, which would result in the inability to have implants and thus dental restorations would be of a traditional modality.

Description of Surgery:

Make an incision on the gun tissue to allow the tissue to be lifted off the cheekbone. A window is carefully cut on the side of the cheekbone leaving the lining of the sinus intact. The lining is then teased away from the walls of the sinus to create a pocket. A suitable bone graft material is then placed into the pocket, and the gum tissue is then reseated onto the cheekbone. The edges of the incision are sewed together.

Risks:

- Normal surgical complications of pain, bleeding and bruising.
- Loss of graft due to infection.
- Tearing of the lining to an extent that repair is not possible at time of surgery, and thus, the augmentation procedure would have to be aborted.
- Slight bleeding from the nose.
- Possible subtle modification of the tonal quality of speech and sounds which is usually not noticeable.
- Possible devitalization of adjacent teeth.

Benefits:

- Allows implant placement.

Success and Service Expectations:

The augmentation is considered successful if an implant can be placed into it. However, the durability of the graft and subsequent implant(s), when placed into a functioning environment, cannot be accurately predicted. Although the long term serviceability of any implant cannot be accurately predicted, there are indications that most implants today will provide good service for many years to come.

Fee for the procedure: Each Side_____ Both Sides_____

Payment in full is expected at or before surgery.

I have read the above and understand the nature of the treatment planned for me. Also, it has been explained to me in greater detail than listed herein the procedures necessary to complete the treatment plan. I hereby authorize Dr. Gregory Smith and whomever he may designate as her assistants or associate to perform all the necessary surgical and restorative procedures needed to accomplish the proposed treatment.

I also authorize the taking of photographs during the course of treatment, and understand that these photographs may be used in lectures, seminars, or consultations for the advancement of implant dentistry.

I read and understand the English language. I have been given the opportunity to ask the doctor questions concerning any aspect of this informed consent.

_____

Patient's signature Date

_____

Dentist's signature Date

_____

Witness's signature Date