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CONSENT FOR SOCKET PRESERVATION PROCEDURE

Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I have been informed by Dr. ________________ of my current condition and recommendations for treatment that include _____________________________ (*i.e., implant placement, sinus lift, etc.*).

In addition to the risks of the primary surgical procedure that have been explained to me, I understand that bone grafting itself involves specific risks. My doctor has explained to me that such risks include, but are not limited to the following:

GENERAL RISKS INVOLVED WITH BANKED BONE (freeze-dried, lyophilized, demineralized, xenografts) OR BONE SUBSTITUTES

_____ 1. Bleeding, swelling, infection, scarring, pain, numbness, or altered sensation (possibly permanent) at the donor site that may require further treatment.

_____ 2. Allergic or other adverse reaction to the drugs used during or after the procedure.

_____ 3. The need for additional or more extensive procedures in order to obtain sufficient bone.

_____ 4. Rejection of bone particles from donor or recipient sites for some time after surgery.

_____ 5. Rejection of the donated or artificial graft material.

_____ 6. The remote chance of viral or bacterial disease transmission from processed bone.

CONSENT

I acknowledge that the above has been explained to my satisfaction, my questions have been answered, and I understand the risks of bone grafting. I am fully aware that a perfect result cannot be guaranteed or warranted. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery. I certify that I speak, read, and write English.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date