CONSNET SINUS LIFT

DC PEARLS
DENTAL BOUTIQUE

Consent for Sinus Lift Surgery

Patient's First Name *

Patient's Last Name *

I hereby authorize Dr. Ardekani and any associates to perform sinus lift in the following area *

SINUS LIFT INFORMATION: Roots of the upper back teeth usually protrude into the sinus floor and once they are removed the sinus enlarges. It is quite common to have insufficient bone depth for placement of a dental implant before the floor of the maxillary sinus is reached. It is still possible to place dental implants by grafting a small amount of bone to the floor of the sinus, hence lifting the sinus floor to where it was prior to tooth loss, allowing the correct length of implant to be placed fully within bone. This procedure is called a sinus lift or sinus augmentation and it is a form of bone graft. It is a well evidenced procedure and has reported success rates of 90% long term. For smaller sinus lifts it may be possible to do the graft though the root form preparation at the time of implant placement, this is a closed or crestal approach sinus lift. The patient will be aware of a tapping pressure sensation as this is carried out. For larger grafts, better visibility is attained by making a small window in the side of the sinus under the gums, this is an open or lateral approach sinus lift. Usually this will lead to bruising and swelling on the side of the face in question.

RISKS RELATED TO THE PROCEDURE: Risks related to sinus augmentation surgery with bone regeneration by the use of demineralized bone allografts may include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, or gum, jaw joint injuries or associated muscle spasms. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) no treatment, with the expectation of: (1) no replacement of missing upper teeth; (2) a less than satisfactory outcome to any form of prosthetic replacement of missing upper teeth; (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.

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, extraction of hopeless teeth to enhance the outcome of this procedure 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.

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.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to maxillary sinus augmentation surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

By signing below, you acknowledge that you have read the above information and had any further queries about the procedure answered by your dentist, and that you consent to the procedure detailed below:

8. Other

Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

Please do not hesitate to ask the doctor or the staff if you have any questions.

* Date *

12/10/2021

Printed name if signed on behalf of the patient

Relationship