



## INFORMED CONSENT FOR SINUS ELEVATION SURGERY

I (Patient Name) \_\_\_\_\_ hereby authorize Dr. \_\_\_\_\_  
(herein called Doctor) to perform maxillary sinus elevation surgery on myself.

**Diagnosis:** My Doctor has told me that I have an insufficient bone height in my upper jaw to place root shaped dental implants of adequate length.

**Recommended Treatment:** In order to be able to place root shaped implants of adequate length in my upper jaw, my Doctor has recommended that my treatment include maxillary sinus elevation surgery. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. Oral antibiotics may be prescribed.

My gum tissue will be pulled back and an opening will be created in the wall at the bottom of my maxillary sinus. After access to the sinus is created, the lining of sinuses will be lifted. Underneath the lining, a bone graft will be placed. This graft may include my own bone, synthetic bone substitute, donor source (human or animal), or a combination of these. Prefabricated membranes may also be used, which, if non-restorable, require a small additional surgical procedure for membrane removal.

Dental implants may or may not be placed at the same time of the sinus lift surgery. Whether implants will be placed at the same time can not be determined with certainty before the procedure, and I understand that implant placement may have to be delayed for as long a time as my Doctor deems advisable.

I understand that unforeseen conditions may call for changes in the anticipated surgical plan. These may include but are not limited to: (1) extraction of teeth, (2) the removal of parts of teeth, (3) inability to start or complete the sinus elevation procedure. I understand that I consent to any such changes as deemed indicated in the opinion of my Doctor. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but not limited to: (1) the need for additional dental work, or (2) the modification of the planned dental work. Some complications could include the need for a referral to other dental or medical specialists. I understand that there maybe additional fees associated with the referral that I will be responsible for.

**Expected Benefits:** The expected benefit is that sufficient bone will be available in my upper jaw to allow placement of root-shaped implants.

**Principal Risk and Complications:** I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to infection, bleeding, swelling, pain, temporary discolouration of my face, increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in the elongation of some teeth and greater spaces between some teeth. Rarely, nerve damage can occur, and infections can spread to other parts of the body.

Nose bleeds can occur, and local infection can spread to the bone (osteomyelitis). Failure of the bone graft can lead to failure of implants placed in the area, or inability to place the implants at a later date. Chronic or acute sinusitis may occur as a result of this procedure. Existing sinusitis may be aggravated or recur more frequently. Complication may be irreversible.

There may be a need for a second procedure if the initial results are not satisfactory. The success of sinus elevation 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 acknowledge, I have reported to my Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

**Alternatives to Suggested Treatment:** Alternatives to the sinus elevation procedure include: (1) no treatment, resulting in an inability to place implants of sufficient length in the area, (2) grafting on top of the bony ridge in the area, (3) anchorage of implants in anatomic areas behind the maxillary sinus (pterygoid plate anchorage), (4) false teeth unrelated to implants, such as removeable partial and complete dentures. Principal risks are: alternative (1) premature loss of short implants; alternative (2) limited potential to obtain more bone; alternative (3) inducement of life-threatening bleeding and severe nerve damage; alternative (4) continued bone loss and inability to comfortably function with false teeth.

**Necessary Follow-Up and Self-Care:** It is important for me to: (1) abide by the specific prescriptions and instructions given by my doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. It is essential that I follow the recommendations regarding the nature and timing of the following implant-related treatment. I also need to inform my Doctor as soon as possible of any complications or symptoms that may relate to the sinus elevation procedure or placement of the graft implants. These symptoms or complications include, but are not limited to nose bleeds, pain, unusual feeling of sinus pressure, fever, swelling, pus formation and reactions to the medications prescribed. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor's office to make appropriate appointments.

**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. The sinus elevation procedure, although not experimental, is fairly new surgical treatment. Its long-term success and potential risks and complications may not be fully known.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The doctor has answered all my questions. I authorize Dr. \_\_\_\_\_ and whomever they may choose as their assistants to perform the proposed sinus elevation surgery.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_