Summit View Periodontics
Consent for Maxillary Sinus Elevation Surgery

Diagnosis: I hereby authorize my Periodontist (herein called "dentist") to perform maxillary sinus elevation surgery on my person. My dentist 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 dentist has recommended that my treatment include maxillary sinus elevation surgery. A local anesthetic will be administered in addition to medications deemed appropriate by my dentist. Oral antibiotics may be prescribed. My gum tissue will be pulled back and an opening will be created in the wall on the side 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. The graft may include my own bone, synthetic bone substitute, human bone obtained from tissue banks, or a combination of these. Prefabricated membranes may also be used, which, if non-resorbable, 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 cannot 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 dentist 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 dentist. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include but is 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.

Expected Benefits: The expected benefit of this surgery is that sufficient bone will be available in my upper jaw to allow for the future placement of root-shaped dental implants.

Principal Risks 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 discoloration of my face, increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between 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. Complications 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 knowledge, I have reported to my dentist 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 procedures 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 removable partial and complete dentures. Principal risks of implant placement without sinus modification are: 1) Premature loss of short implants and associated prosthetics; 2): limited potential to obtain adequate implant orientation and/or spacing; 3): Implant sinus penetration leading to the inducement of severe bleeding, infection, and nerve damage; 4): Continued bone loss and inability to comfortably function with false teeth.

Necessary Follow-Up and Self-Care: It is important for me to abide by the specific prescriptions and instructions given by my dentist, and see my dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. It is essential l that I follow the recommendations regarding the nature and timing of following implant-related treatment. I also need to inform my dentist 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 dentist may inform me when my next periodic visit is needed, I am responsible for contacting the dentist'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. My individual condition may require re-treatment or alternative treatment options.

Publication of Records: I authorize that my dental records, slides, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

Patient Consent: I have read this entire form and understand everything explained in it. I have had the opportunity to ask the dentist 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 dentist has answered all my questions.

_____	_____	_____
Date	(Signature of patient/parent/guardian)	(Printed name of patient/parent/guardian)
_____	_____	
Date	(Dentist's signature)	
_____	_____	_____
Date	(Signature of witness)	(Printed name of witness)