

LLOYD KITCHIN, D.M.D (973) 584-2533

CONSENT FOR BONE GRAFTING PROCEDURE

Patient's 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. Kitchin of my current condition and recommendation for treatment that includes _____ (i.e., implant placement, sinus lift, etc.).

In addition to the risks of the primary surgical procedure that have been explained to me separately, I understand that bone grafting 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