

Goehring Dental

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Consent for Maxillary Sinus Lift Surgery

Diagnosis:

Dr. Goehring/Badea has informed me that I have 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 the root shaped implant/s of adequate length in my upper jaw, Dr. Goehring/Badea has recommended that my treatment include maxillary sinus elevation surgery. A local anesthetic will be administered in addition to medications deemed appropriate by Dr. Goehring/Badea. Oral antibiotics will also be prescribed.

My gum tissue will be reflected and an opening will be created on the side of my maxillary sinus. After access to the sinus is created, the ling of the sinus will be lifted and 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. Additional materials (collagen barrier membrane) may be used.

I understand that the graft material must be in place for 6-9 months before placement of implants.

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 although complications are rare, unforeseen conditions may call for changes in the anticipated surgical plan. These may include, but are not limited to: extraction of teeth, the removal of parts of teeth, and 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 Dr. Goehring/Badea. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: the need for additional dental work, or the modification of the planned dental work. Some complications could include the need for referral to other dental or medical specialists.

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 Dr. Goehring/Badea any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

I understand that complications may result from the surgery and/or any drug used. These complications may include, but are not limited to:

1. Pain and swelling of the surgical area, ear, neck and head that may require several days of at home rest. Temporary bruising of the face, neck, eye and mouth may also occur.
2. Injury to the nerve branches resulting in numbness and tingling of the: lower eyelid, upper lip, side of nose, chin, cheek, gums, palate and/or teeth, which may be temporary or permanent.
3. Infection that might require further treatment, including removal of the graft, hospitalization and surgery.
4. Failure of the bone graft may lead to a second procedure if the initial results are not satisfactory, failure of the implants placed in the area, or the inability to place the implants at a later date.
5. Postoperative complications involving the sinuses (chronic or acute sinusitis, perforation of the sinus membrane), nasal cavity (nose bleeds), sense of smell, and altered sensations of the upper cheek and eyes.
6. Smokers should not smoke one day prior to surgery, the day of surgery and at least one day following surgery. Not smoking for one week prior and two weeks after surgery if preferred.
7. Injury of the teeth or roots to include, but not limited to: tooth loss, tooth looseness and sensitivity to hot, cold, sweet, or acidic foods, which may require root canal treatment.
8. Bleeding which may require blood transfusions or other means of control.
9. Postoperative unfavorable reactions to drugs, such as nausea, vomiting and allergy.

- 10. Restricted mouth opening, limitation of jaw function or stiffness of facial and jaw muscles.
- 11. Shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth.

Alternatives to Suggested Treatment:

Alternative	Principal Risks
No treatment	Inability to place implants of sufficient length in the area; premature loss of short implants; continued bone loss
Grafting on top of the bony ridge in the area	Limited potential to obtain more bone
Removable partial or complete dentures	Continued bone loss and possible 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 Dr. Goehring/Badea, and (2) see Dr. Goehring/Badea and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. I also need to inform Dr. Goehring/Badea as soon as possible of any complications or symptoms that may relate to the sinus elevation procedure or placement of the graft. These symptoms or complications include, but are not limited to: nose bleeds, small particles of graft material from the nose, pain, unusual feeling of sinus pressure, fever, swelling, pus formation and reactions to the medications prescribed.

No Warranty or Guarantee:

It is understood that although good results are expected, I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. 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 Dr. Goehring/Badea 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. Dr. Goehring/Badea has answered all my questions. I hereby authorize Dr. Goehring/Badea to perform maxillary sinus elevation surgery to my:

Upper right side

Upper left side

Signature of Patient

Date

Signature of Parent or Guardian

Date

Signature of Witness

Date

Signature of Dr. Dennis P. Goehring/Dr. Luana Badea

Date