



## HUNTINGTON SMILES

100 E. Huntington Drive, Suite 206 Alhambra, CA 91801 (626) 308-7881

### SINUS LIFT SURGERY CONSENT

**Patient Name:** \_\_\_\_\_

If you have any questions about this form, please ask the dentist before signing it. Sinus lift surgery is performed in conjunction with the placement of dental implants in order to create the necessary amount of bone needed for implant placement. A sinus lift is performed to return the level of the sinus floor to a height that will be adequate for implant placement. The surgery will require placement of either a bone substitute, autogenous (my own) bone, or a mixture of the two in order to achieve the added bone height needed for dental implants.

#### **SURGICAL CONSIDERATIONS**

The surgery is performed with gum incisions in the back upper jaw. Once the sinus is entered, the sinus membrane will be elevated intact and the bone graft placed to lift and create a new sinus floor. Stitches will then be used to secure the gum tissue and care must be taken to allow for healing.

I understand that use of tobacco during the healing period will decrease my chances of a successful sinus lift and bone healing and may also increase my chances of infection.

#### **POSTOPERATIVE CONSIDERATIONS**

Postoperative discomfort should be expected as well as a degree of swelling over the cheek that varies for each patient. Occasionally, there may be some bloody discharge from the nose. I understand that it is important for the grafted bone to heal without infection and I agree to refrain from nose blowing and straw use for 10 days after the procedure. Sneezing should be done with the mouth open. I have read and understood the postoperative instruction sheet and agree to follow the guidelines for uncomplicated healing.

#### **PRINCIPAL RISKS AND COMPLICATIONS**

It has been explained to me that there are certain inherent risks in any surgical treatment and, although rare, that in this specific instance such treatment risks include, but are not limited to: Infection and/or rejection of grafted bone resulting in inadequate bone volume for dental implant placement, symptoms of sinusitis which are usually temporary, but may be rarely permanent. Graft migration, which may necessitate graft removal. Excessive bleeding, transient but on occasion permanent numbness of the lip, teeth, or gum, jaw joint injuries or associated muscle spasms.

#### **ALTERNATIVES TO THE PROCEDURE**

These may include: (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.

#### **CONSENT**

I certify that I have had an opportunity to fully read this consent. My signature below indicates my understanding of the proposed treatment and I hereby give my willing consent for the placement of dental implants, sinus lift surgery, the placement of autogenous bone and/or bone substitute in the sinus to lift the sinus floor.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Doctor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_