

“All About You” Dental

We'll go the Extra Mile for You! Reconstruction Surgery Consent Form

The reconstructive surgery procedure has been explained to me and I understand what is necessary to accomplish the reconstruction procedure under the gum tissue and with the bone. I also understand what is necessary in rebuilding, modifying, or reconstructing the bone and/or gums to make this surgery successful. I understand the grafting materials have had FDA testing and approval. One of the doctors of All About You Dental have carefully examined me. To my knowledge, I have given an accurate report of my health history. Any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollen, dust, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions concerning my health are included.

I understand that any of the following may occur: bone disease, loss of bone and/or gum tissue, inflammation, swelling, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint problems, headaches, referred pains to the back of the neck and facial muscles, the doctor has explained to me that there is no method to accurately predict the gum and bone healing capabilities in each patient following the surgery. I understand that smoking, alcohol, or departures from acceptable dietary practices may affect gum and bone healing and maintenance. This may limit the success of the recommendations per my doctor's instructions. I agree to report for recall examinations and maintenance every 3 months or as instructed.

I have been informed and understand that occasionally there are complications of surgery, drugs and/or anesthesia. Pain, swelling, infection, discoloration, and numbness of the lip, chin, face, tongue, cheek, or teeth may occur, the exact duration of which may not be determined. The numbness may be irreversible. Also possible are inflammation of a vein, injury to teeth if present, bone fractures, nasal or sinus penetration, delayed healing and allergic reactions.

With full understanding, I authorize the doctors of All About You Dental to perform the services for me.

I authorize photos, slides, videos, x-rays, or any other viewing of my care and treatment during its progress to be used for the advancement of dentistry. If it is in my best interest, I approve any modification in design and materials in the professional judgment of the doctors of All About You Dental.

If for any reason I leave the doctor's care as he recommends it, I release him from the responsibility for my continuing oral health.

I understand that there is no warranty or guarantee as to any result. I am further advised that I can get additional explanations of risks before or during the progress of my treatment merely by asking.

Understand the above, I request the doctors of All About You Dental to perform the operation _____ on me.

Date Signed Patient Witness

Printed Name

Date Parent/Guardian Witness