Bone Grafting/Surgical Consent Form

1. I have been informed and I understand the purpose and the nature of oral surgery/grafting procedure.

2. My doctor has carefully examined my mouth and explained the procedure to be performed.

3. I understand that there is the possibility of swelling, pain, infection, paresthesia (numbness) and ecchymosis (bruising) , injury to adjacent teeth, sinus complications, delayed healing and allergic reaction to medications.

4. The procedure has been explained to me and I understand other options of treatment.

5. I understand that excessive, smoking, alcohol, or sugar may affect gum healing as well as certain medical conditions, stress and debilitating state. I agree to follow my Doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed during and after completion of sugery.

6. To my knowledge I have given an accurate report of my physical and mental history. I authorize my dentist to make photos, slides, x-rays or any other visual aids for the advancement of dental education.

7. I request and authorize medical-dental services for me, including oral or periodontal surgery required. I fully understand therefore, that during, and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgement of the Dr., additional or alternative treatment pertinent to the success of comprehensive treatment.

I _____consent to surgical procedures performed by:_____ Date:_____

Signature of Patient or Guardian	Signature of Doctor	Signature of Witness