CONSENT FOR MAXILLARY SINUS REPAIR SURGERY

I,_____, hereby authorize Drs. Pomeranz/Arguello/Marcuschamer to perform maxillary sinus repair surgery on myself.

Diagnosis: My doctor has told me that I have a sinus communication between my sinus cavity and the external oral environment.

Recommended Treatment: In order to close this communication Drs. Pomeranz/Arguello/Marcuschamer has recommended that my treatment include maxillary sinus access with possible tissue grafting surgery. A local anesthetic will be administered in addition to medications deemed appropriate by Drs. Pomeranz/ Arguello/Marcuschamer. Oral antibiotics may be prescribed.

My gum tissue will be pulled back and an access to the opening of the maxillary sinus will be created. After access to the sinus a new lining of the sinus will be created by harvesting a tissue from the inner aspect of my gums in the roof of my mouth and on occasion, a bone graft will be placed as determined by the doctor at the time of the surgery. This graft may include my own bone, synthetic bone substitutes, human bone obtained from tissue banks, or a combination of these.
Prefabricated membranes may also be used.

Dental implants may or may not be an option for me in the future and it will be determined at a later time after initial healing has been completed.

I understand that unforeseen conditions may call for changes in the anticipated surgical plan. These may include, but are not limited to: (1) extraction of teeth, (2) the removal of parts of teeth, (3) 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 Drs. Pomeranz/Arguello/Marcuschamer.
Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) modification of the planned dental work. Some complications could include the need for a referral to other dental or medical specialists.

Expected benefits: The expected benefit is that the existing perforation is expected to be closed but not guaranteed and it may require an additional surgical procedure.

Principal Risks and Complications: I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to infection, bleeding, swelling, pain, temporary discoloration of my face, increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Rarely, nerve damage can occur and infections can spread to other parts of the body. Nose bleeds can occur and local infection can spread to the bone (osteomyelitis). Failure of the bone graft can lead to failure of the implants placed in the area, or inability to place the implants at a later date. Chronic or acute sinusitis may occur as a result of this procedure. Existing sinusitis may be aggravated or recur more frequently. Complications may be irreversible.

There may be a need for a second procedure if the initial results are not satisfactory. The success of sinus elevation procedure 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 Drs. Pomeranz/Arguello/Marcuschamer any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

Alternatives to Suggested Treatment: alternatives to the sinus repair procedure include: (1) no treatment, resulting in an inability to place implants of sufficient length in the area and to remain with such communication. (2) grafting on top of the bony ridge in the area (3) false teeth unrelated to implants, such as removable partial and complete dentures.

Necessary Follow-Up and Self-care: It is important for me to: (1) abide by the specific prescriptions and instructions given by Drs. Pomeranz/Arguello/Marcuschamer and (2) see Drs. Pomeranz/Arguello/ Marcuschamer and my regular dentist for periodic examinations and preventive treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. It is essential that I follow the recommendations regarding the nature and timing of following related and recommended treatment. I also need to inform Drs. Pomeranz/Arguello/Marcuschame as soon as possible of any complications or symptoms that may relate to the sinus elevation procedure or placement of the graft or implants. These symptoms or complications include, but are not limited to nose bleeds, pain, unusual feeling of sinus pressure, fever, swelling, pus formation and reactions to the medications prescribed. Although Drs. Pomeranz/Arguello/Marcuschamer will inform me when the next periodic visit is needed, I am responsible for contacting Drs. Pomeranz/ Arguello/Marcuschamer's office to make appropriate appointments.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. This sinus repair procedure, although not experimental, is a fairly new surgical treatment. Its long term success and potential risks and complications may not be fully known.

Publication of Records: I understand that photographs, video, study models, radiographs and other diagnostic aids may be taken or used as a part of this procedure. I give my permission to Altura Periodontics for their use for educational, scientific and marketing purposes, including publication.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask Drs. Pomeranz/Arguello/Marcuschamer 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 and substantial risks of the alternative treatment methods. Drs. Pomeranz/Arguello/Marcuschamer has answered all my questions. I authorize Drs. Pomeranz/Arguello/ Marcuschamer and whomever they may choose as their assistants to perform the proposed sinus elevation surgery.

_____ _____

(signature of patient or legal guardian) (witness)

_____

Date