SCHOFIELD DENTAL

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. Dr. Schofield has 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 Dr. Schofield 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 Dr. Schofield.

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 Dr. Schofield to perform the operation _____ on me.

_____	_____	_____
Date	Signed Patient	Witness
	_____	
	Printed Name	
_____	_____	_____
Date	Parent/Guardian	Witness