DISCOVER DENTAL

Informed Consent
SINUS LIFT

This is my consent for Dr. Jeremie Hallett to perform the recommended **sinus lift procedure** as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned procedure.

I hereby authorize and request that Dr. Jeremie Hallett, and any other agent or employees of and such assistants as may be selected by him, to perform corrective surgery on my upper jaw (maxilla). This procedure may involve the grafting of bone, including a combination of freeze dried demineralized bone (bovine bone, and/or human cadaver bone) and autogenous bone (my own bone), into the floor of the sinus in the hope that my body will create new bone and incorporate it into the grafted material thus allowing for a stable implant.

I understand that a second procedure may be needed to place the dental implant(s). It is hoped that the implants will become stable and act as anchors for fixed or detachable crowns, bridges or dentures. I understand that if this grafting procedure is not successful that alternative procedures and/or prosthetic measures will have to be considered. Dr. Hallett has described the sinus lift operation to my satisfaction. It is understood that although good results are expected, no guarantee of success or longevity has been given. I understand that occasionally there are complications to any surgery, drugs and anesthesia, including, but not limited to:

1. Pain, swelling and postoperative discoloration of face, neck and mouth.
2. Numbness and tingling of the upper lip, gums, teeth, cheek and palate, which may be temporary, but may be permanent.
3. Infection of the bone that might require further treatment, including hospitalization and surgery.
4. Mal-union, delayed union or non-union of the bone grafting material to normal bone, or lack of adequate bone growth into the material.
5. Bleeding which may require blood transfusions or other extraordinary means to control.
6. Stiffness of facial and jaw muscles resulting in limitation of jaw function.
7. Injury to the teeth.
8. Referred pain to the ear, neck and head.
9. Postoperative complications involving the sinuses, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the upper cheek and eyes.
10. Unfavourable reactions to drugs, such as nausea, vomiting and allergy.
11. Possible loss of teeth and bone segments.

I understand that every reasonable effort will be made to ensure that the surgery is completed properly, although it is not possible to guarantee perfect results. I further understand that I am free to withdraw from treatment at any time. I also give permission for photography, filming, recording and x-rays of the procedure to be performed for the purposes of marketing, teaching and research, provided my identity is **not** revealed.
I certify that I have had an opportunity to read and fully understand the terms and words within this consent and the explanations made. I acknowledge that all of my questions related to this procedure have been answered to my satisfaction. I understand this consent form and I request Dr. Hallett to perform the discussed surgery.

PATIENT NAME	
First Name	
Last Name	

SIGNATURE
28-Jun-2014