BELTRAN DENTAL SURGERY

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# Informed Consent and Release for Oral-Antral Fistula Repair or Sinus Augmentation

I, ___, authorize Doctor Jose Luis Beltran and his associates to perform

- Repair of an Oro-antral Fistula at site #___
- Right and / or Left Sinus Augmentation with cadaveric bone graft
- Administration of local anesthesia, nitrous oxide, intravenous sedation
- and any other procedures deemed necessary at the time of surgery.

Doctor Beltran has explained the procedure in detail and the results of such treatment. I understand that this is an elective procedure and that there are other forms of treatment available including the option of no treatment. The possible risks if oral surgery is not performed include but are not limited to infection, cyst or tumor formation, increased risk for complications if oral surgery is delayed.

Doctor Beltran has explained to me that there are certain potential risks in this treatment plan or procedure which include:
-Failure or loss of implant and/or bone graft.
-Injury to the nerves that give sensation to the lower lip and tongue causing numbness or change of sensation that can be permanent.
-Injury to adjacent teeth, fillings, or crowns.
-Adverse reaction or allergies to prescribed medications.
-Infection to surgical area which may require additional treatment.
-Recurrent communication between mouth and maxillary sinus (also known as sinus exposure or, oro-antral fistula)
-Temporal mandibular joint pain, aggravation of prior disease, or dislocation of the joint.
-Fracture of the maxillary or mandibular bone, if lesion has progressed to involve bone
-Additional necessary procedures.

-**Osteonecrosis** or non-healing of bone at extraction site, if I have had head or neck radiation or cancer or bisphosphonate medication: Aredia(Pamidronate), Zometa(Zoledronate), Xgeva(Denosumab), Fosamax(Alendronate), Actonel(Residronate), Boniva(Ibandronate), Didronel(Etidronate), Skelid(Tiludronate), Reclast(Zoledronic Acid), Evista(Raloxifene), Fortoe Pen(Teriparatide), Miacalcin(Calcitonin)

-**Smoking** cigarettes or cigars or chewing tobacco causes irritation, delayed or non-healing, increased swelling, increased pain, increased risk of infection and dry socket of the surgical site

***I have thoroughly read each line and understand the informed consent. I have had all my questions answered by the staff. I agree to the treatment and am knowledgeable of the possible risks of the procedure.***

**Patient's Signature:**

**Witness:** **Date:**

Doctor Beltran also explained to me that the following conditions **commonly** happen after oral surgery, and are especially more pronounced with the use of **tobacco products**:
-Pain. The pain medication will help you **tolerate** the pain better, but most of the time it does **not** make you pain free.
-Bleeding.
-Facial swelling which peaks on the 3rd to 5th day and then decreases.
-Facial bruising (black-blue discoloration of the face) lasting up to 2 weeks.
-Dry socket or alveololitis.
-Trismus or tightness of the chewing muscles may limit mouth opening.
-Referred pain or radiating pain to the ear and other teeth.
-Sore throat.
-Temporary numbness of the lower lip which may last up to several months.
-Sore or cracked lips or corners of the mouth.
-Bone level resorption at the site of extraction.
-Sore throat.
-Minor fever 24 to 48 hours after surgery.
-Bony spicules

-I, , understand that the medications, anesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they increase these effects. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I have been advised not to work or operate any vehicle or heavy machinery until I have fully recovered from the effects of the medications.

***I have thoroughly read each line and understand the informed consent. I have had all my questions answered by the staff. I agree to the treatment and am knowledgeable of the possible risks of the procedure.***

**Patient's Signature:**

**Witness:** **Date:**