CONSENT FOR ALVEOLOPLASTY

I understand that Alveoloplasty, or smoothing and reshaping of bone, will be performed either in conjunction with extractions or on its own to enhance healing and prepare the jaw bone for future restorations, such as dentures. Even though care and diligence will be exercised by my treating dentist, there are inherent risks associated with any procedure. I agree to assume those risks, including possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Bleeding**: Significant bleeding is not common, but oozing can be expected for the first 24-48 hours following treatment. In patients taking blood thinners or anticoagulants, it can take longer for blood clots to form. If there is severe bleeding 4 hours after treatment, please call the office immediately.

2. **Infection**: Despite the use of sterile surgical instruments, it is possible for infection to occur post-operatively. At times these may become severe. Should a fever and swelling occur, especially if it impairs the patient's ability to speak, swallow, or breath, medical attention should be sought immediately. In some cases hospitalization and/or treatment with IV antibiotics may be necessary. If antibiotics are prescribed following treatment, women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the treatment period.

3. **Sharp ridges or bone splinters**: These may occur as healing progresses. Sometimes the body "works them out" without assistance, but in some cases an additional procedure may be needed to smooth or remove them.

4. **Adjacent Damage**: Damage to existing fillings, crowns, bridges, veneers, or natural teeth can occur necessitating placement or replacement of a restoration. Tissue laceration or abrasion may require sutures (stitches). Stretching of the corners of the mouth can result in cracking and bruising of the lips and/or tissue around the mouth.

5. **Muscle or jaw pain and soreness**: Swelling, discomfort and/or bruising may be noticed following dental treatment. Pre-existing TMJ (jaw joint) conditions may be aggravated by dental treatment. Clicking, popping, muscle soreness, and difficulty opening (trismus) may be noticed following treatment. If symptoms persist, the patient should contact the office. The patient must notify the doctor of any pre-existing conditions prior to treatment.

6. **Nerve Injury**: Injury to the nerves, although infrequent, can cause numbness (anesthesia), tingling/burning (paresthesia), or altered sensation in the teeth, lip, tongue, chin, and the tissues in the floor of the mouth. This change in sensation may be temporary lasting a few days to a few months, or could possibly be permanent.

7. **Unusual reaction to medications**: Reactions, either mild or severe, may possibly occur from anesthetic or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. If any medications prescribed cause nausea and/or vomiting, please call the office immediately.

Initials____

8. **Bisphosphonate drugs**: For patients who have taken Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone, like in osteoporosis or for treatment of metastatic bone cancer, are at an increased risk of osteonecrosis (failure of the bone to heal properly) following any oral procedure involving the bone, including alveoloplasty. The patient must notify the doctor of any medical conditions and medications that have been or are currently being taken for bone health.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of alveoloplasty, and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any. No guarantees or promises have been made to me concerning the results of treatment to be rendered. The fees for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize the doctors at Thrive Dental & Orthodontics to render any treatment necessary or advisable to mine or my dependent's dental conditions.

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Patient's Name (please print)

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Signature of Patient, Legal Guardian, or Authorized Representative Date

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Witness' Signature Date