REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR ALVEOLOPLASTY

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.

- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s): Alveoloplasty
- ❑ I understand that this treatment is termed Alveoloplasty is accomplished by reshaping the alveolar bone. This is the horseshoe shaped bone teeth are rooted in. The alveolar bone sits on the basal bone of the maxilla (upper jaw) and mandible (lower jaw). Any time a tooth is removed alveoloplasty may be required to smooth rough or sharp edges to reduce protruding bone. When alveoloplasty is preformed it is done in the most conservative manner possible. Preservation of the bone is important because it naturally diminishes over time. When preparing the mouth for dentures the alveolar bone may need to be shaped so the denture can fit over it. If overhanging bone creates undercut the bone must be reshaped.
- ❑ These procedures are necessary to treat the following condition(s): to improve the alveolar ridge form in order to support, or otherwise help stabilize, a denture, dental implant or bridge . The alveolar ridge is the ridge of bone the teeth are normally rooted into.
- ❑ The possible alternate methods of treatment (if any), include: If this treatment is not done, I understand my choices are: to continue wearing the denture or appliance I have at present; remake my present appliance to try to improve the fit; undergo surgical procedures to reposition muscle attachments or otherwise attempt to extend the deficient ridge; surgically place implants to support my present appliance; or:
- ❑ I understand that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:
  - ❑ Numbness, pain or tingling of the chin, lips, tongue (including possible loss of taste sensation), cheek or gum tissue. These symptoms may persist for weeks, months, or, in rare instances, may be permanent.
  - ❑ Swelling and discomfort and some difficulty chewing and swallowing for a time.
  - ❑ Bleeding, bruising and possible formation of a hematoma (clot) in the tissues of the floor of the mouth that may remain for several days and require additional care.
  - ❑ Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
  - ❑ Allergic reactions to drugs or medicine used during treatment.
  - ❑ Damage to adjacent teeth or tooth roots.
  - ❑ Fracture of the jaw or thin portions of the jaw.
  - ❑ Post-operative infection that may require additional treatment, including loss of the graft.
  - ❑ Other:_____

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

- ❑ I understand smoking is extremely detrimental to the healing process. **I agree to cease all use of tobacco for 6 weeks prior to and 6 months after surgery and to make strong efforts to give up smoking entirely.**
- ❑ Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.
- ❑ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the treatment would be helpful, and I have weighed the risk with the proposed benefits.
- ❑ I have discussed my past medical history with the doctor and have disclosed **ALL** diseases and medications, including alcohol and drug use past and present.

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- ❑ I agree to cooperate completely with the recommendations of Dr. Reynolds/Dr. Auble, realizing that lack of cooperation may result in a less than optimal result.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.
- ❑ I understand that oral hygiene will be difficult following surgery, but will do my utmost to follow normal tooth brushing and oral hygiene routines.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date