

**DISCLOSURE AND CONSENT  
MEDICAL AND SURGICAL PROCEDURES**

*To the patient: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I (We) voluntarily request Dr. Barry W. Heaton (hereinafter called Doctor), and such associates, technical assistants and other health care providers as Doctor deems necessary to treat my condition which has been explained to me as:

**MAKE ROOM FOR IMPLANT**

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I (We) understand that the following surgical procedures are planned for me and I(we) voluntarily consent and authorize the following procedure(s):  
**SINUS LIFT**

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I(We) understand that no warranty or guarantee has been made as to the result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical procedure planned for me. I realize that in surgical procedures the potential for infection and hemorrhage can occur.

I(We) understand that the risks of the proposed procedure can include, but are not limited to swelling, infection, prolonged bleeding, pain for several days, restricted jaw and mouth opening for several days, gum recession (shrinkage of gums; teeth appearing longer than before), temporary or, in rare cases, permanent interference with phonetics (speech), tooth sensitivity for several days, weeks or several months, tooth mobility, food lodging between teeth after meals that require cleaning services such as floss for removal, and unaesthetic exposure of crown margins.

I(We) agree to cooperate completely with the recommendations of the Doctor and will return for follow-up visits as advised by the Doctor and realize that failure to do so could result in a less than optimum result.

I(We) have had the opportunity to discuss with the Doctor my past medical and health history including any serious problems and/or injuries. I(We) understand that certain conditions including uncontrolled diabetes, smoking, immunodepression, and alcohol consumption can adversely affect healing after surgery.

I(We) understand that the practice of periodontics is not an exact science and that reputable practitioners cannot guarantee results. No guarantee, warranty or assurance has been given to me regarding the success of the proposed treatment or that it will be successful to my complete satisfaction. Due to differences in individual patients, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition to include the possible extraction of certain involved teeth despite the best of care. It is the Doctor's professional opinion that therapy will be beneficial and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

The fee for service has been explained to me and is satisfactory. I(We) understand that the fee is only for the procedure(s) described above and corresponding post-operative visits and that if additional procedures are necessary, additional fees will be assessed. If future additional procedures such as re-treatment, reshaping of tissue, or recontouring of tissue attendance to post-operative complication should become necessary, an additional professional fee will be assessed for same and is not included as part of this procedure. I understand that the cost of additional care provided by another specialist, physician, hospital, therapist or other healthcare provider due to any postoperative complications is the patient's responsibility.

I(We) understand that long-term success requires my continued performance of mechanical plaque removal (daily home care) as instructed by the Doctor and by my availability for periodontal maintenance recalls up to every three months at the Doctor's office. I understand that there is no cure for periodontal disease and that periodontal procedures are intended to stop the progression of the disease and correct areas of the gums that have been damaged by the disease. It is possible to have a relapse and disease progression, even with the best of care.

I(We) understand that certain risks are involved with receiving local anesthetic, including soreness, infection, allergic reaction, adverse drug reaction, headache, nausea, vomiting, hematoma (rupturing of vessels or artery), or restricted jaw opening (lockjaw). I authorize the Doctor to administer local anesthetic and other medications such as sedatives that may be needed during the course of my treatment. I further request and authorize the Doctor to do whatever he may deem advisable based on his findings during the procedure.

I(We) hereby request and authorize the proposed surgery and administration of local anesthetic.

**I(We) certify that I(we) have read and fully understand the information above and consent to the procedures and the explanation therein referred to or made. I(We) have been given ample opportunity to ask questions and all were answered to my satisfaction.**

Print patient name: \_\_\_\_\_ Patient/Guardian Signature: \_\_\_\_\_

Translator: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_