

Ronald Katz DDS

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732.422.006

Patient Name: _____

Date: _____

Bone Grafting Surgical Consent Form

1. I have been informed and I understand the purpose and the nature of oral surgery/grafting procedure. I understand that synthetic; or sterilized human allograft or sterilized animal bone may be used to rebuild my lost structures.
2. My Doctor has carefully examined my mouth and explained the procedures to be performed.
3. I understand that there is the possibility of swelling, pain, infection, paresthesia (numbness), and ecchymosis (bruising), injury to adjacent teeth, sinus complications, delayed healing and allergic reaction to medications.
4. The procedure has been explained to me and I understand other options of treatment.
5. I understand that excessive smoking or alcohol may affect gum healing as well as certain medical conditions, stress and a debilitating state. I agree to follow my Doctor's home care instructions. I agree to report to my Doctor for regular examinations as instructed during and after completion of surgery.
6. To my knowledge I have given an accurate report of my physical and mental history. I authorize my dentist to make photos, slides, X-rays or any other visual aids for the advancement of dental education.
7. I request and authorize medical-dental services for me, including oral surgery or bone grafting as required. I fully understand, therefore, that during and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment.

I, _____, consent to the surgical procedures performed by
Ronald Katz D.D.S.

Signature of Patient or Guardian: _____ Date: _____

Signature of Doctor: _____ Date: _____

Signature of Witness: _____ Date: _____