

**MARK D. BRANNON D.D.S.**

**CONSENT FOR BONE GRAFTING PROCEDURE**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

**Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.**

I have been informed by Dr. Brannon of my current condition and recommendation for treatment that includes \_\_\_\_\_ (i.e., implant, sinus lift, etc.)

In addition to the risks of the primary surgical procedure that have been explained to me separately, I understand that bone grafting itself involves specific risks. My doctor has explained to that such risks include, but are not limited to, the following:

**GENERAL RISKS INVOLVED WITH BANKED BONE** (freeze-dried, lyophilized, demineralized, xenografts) **OR BONE SUBSTITUTES**

- \_\_\_\_ 1. Bleeding, swelling, infection, scarring, pain, numbness or altered sensation (possibly permanent) at the donor site that may require further treatment.
- \_\_\_\_ 2. Allergic or other adverse reaction to the drugs used during or after the procedure.
- \_\_\_\_ 3. The need for additional or more extensive procedures in order to obtain sufficient bone.
- \_\_\_\_ 4. Rejection of bone particles from donor or recipient sites for some time after surgery.
- \_\_\_\_ 5. Rejection of the donated or artificial graft material.
- \_\_\_\_ 6. The remote chance of viral or bacterial disease transmission from processed bone.

**CONSENT**

I acknowledge that the above has been explained to my satisfaction, my questions have been answered, and I understand the risks of bone grafting. I am fully aware that a perfect result cannot be guaranteed or warranted. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery. I certify that I speak, read, and write English.

\_\_\_\_\_  
Patient's (or legal guardian's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date