Consent Form for Alveolar Bone Grafting treating Alveolar Ridge Deficiency

Dental Hospital

Patient Information

Name.....Age..... years HN .....WARD.....

Scheduled procedure ..... Date .....

I, ..., hereby consent to the treatment and/or surgical procedure performed by Dr. ..... and their medical team to address my condition or that of the person under my guardianship, using the following method(s):

.....

This procedure can be explained in simpler terms as follows:

.....

1. I have been thoroughly informed by the dental/ medical team about the benefits, risks, and procedural details of the treatment. Additionally, I have been informed about alternative treatment options that may be available for my condition, allowing me to make an informed decision. I fully understand that I have the right to refuse the proposed treatment.

2. Risks and possible complications including

2.1 General complications include infection and inflammation, swelling, bleeding, failure of the bone graft and tissue rejection, pain or numbness at the surgical site, scarring.

2.2 Specific complications related to iliac crest bone graft include fracture of the iliac crest, injury to the abdominal region, reduced intestinal motility (which may cause nausea, vomiting, or abdominal discomfort), hernia, and gait disturbance.

2.3 Other complications :

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3. The medical team reserves the right to modify the treatment as necessary to achieve the best possible outcome. In the event of any failure or complications following the procedure, I agree to be responsible for any additional costs incurred.

4. Financial disclosure

The Operating Room Nurses and Benefits Unit Officers have informed me in detail about the treatment costs, including surgical fees, hospital equipment costs, anesthesia fees, and other necessary materials. Additionally, I have been informed about which expenses are covered by my medical benefits and which are not (in cases where I am eligible for medical benefits such as health insurance, government benefits, social security, local administrative organization benefits, etc.).

5. I fully understand and accept all the information stated above without any doubts and am prepared to undergo the procedure accordingly.

Signature: .....
(.....)
Treating Dentist

Signature: .....
(.....)
Patient / Authorized Representative
Relationship to the patient: .....

Signature: .....
(.....)
Witness

Signature: .....
(.....)
Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.