



dental

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## CONSENT FOR SINUS AUGMENTATION SURGERY

I have been informed that in order to avoid or eliminate a removable partial or complete denture, and to have a dental implant-supported appliance placed in my upper jaw, I will require a graft procedure to try and create adequate bone quantity and quality in the area of my maxillary sinus(es). This involves creating a “window” into part of the sinus cavity, moving the sinus membrane upward, and placing graft material into that portion of the sinus cavity to encourage bone growth. Generally, 6 to 12 months are needed for adequate maturation of the graft.

I understand that there are some risks involved, which include the possibility of rejection or failure of the graft materials and/or implants. Additional risks include:

- sinus perforation or infection which could ultimately result in poor or delayed healing, or communication with the nasal or oral cavities, possibly requiring additional surgical procedures.
- discoloration (black and blue) of the face or jaws; post-operative bleeding or the possibility of a nosebleed.
- future failure of the graft or dental implants, resulting in loss of implants and the attached dental appliance, or requiring an appliance different from that originally proposed or placed.
- unfavorable patient factors, such as uncontrolled diabetes and other medical conditions, a history of sinus problems, smoking, excessive clenching/grinding of the teeth, excessive alcohol consumption, and poor oral hygiene.
- injury to natural teeth, or an alteration in sensation to the teeth or gums.

The materials used for the graft may include the use of prepared human and/or animal substances (such as powdered bone), and I agree to this. I understand that these substances are obtained from accredited bone banks or commercial sources, and the materials have been processed in accordance with current standards. I am expected to take all prescribed medications as directed.

I understand that there can be no warranty or guarantee of results. Additional explanations of risks have been provided to me and I can ask any further questions during the course of treatment. I understand the procedure and risks, and agree to them.

Signed: Patient \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_