VISAGE SURGERY CENTER
Oral & Maxillofacial Surgery
Facial Cosmetic Surgery
FAISAL A. QUERESHY, MD,DDS,FACS, INC.
BOARD CERTIFIED • MEDICAL DIRECTOR

Consent for Bone Graft from the Mouth

I hereby authorize **Faisal A. Quereshy, M.D., D.D.S.**, as a qualified Maxillofacial Surgeon, and such assistants as he may designate, to perform upon:

Please initial each paragraph after reading. If you have any questions, please ask Dr. Quereshy <u>BEFORE</u> initialing:

____1. An operation for the purpose of improving function and/or appearance and overall quality of life, with respect to the following condition(s):

Maxillary/mandibular bone atrophy

____2. The specific proposed operation, to which I agree to submit, is as follows:

Autogenous bone graft from the oral cavity site:_____

____3. I hereby swear that the operation(s) to correct the aforementioned condition(s) have been thoroughly explained to my satisfaction and, in addition, the specified risks involved have been explained and include, among others outlined, the following major complications:

1. Damage to adjacent teeth
Removal of teeth to obtain bone
Bleeding/bruising/swelling
4. Numbness/pain, temporary/permanent
5. Penetration of sinus or nasal cavity causing infection
6. Rejection of the bone graft

____4. I furthermore know and understand that the practice of Medicine and Surgery is not an exact science, and that, reputable physicians cannot guarantee any specific results. No guarantee(s) or assurance has been given to me by **Faisal A. Quereshy, M.D., D.D.S**., or his staff, as to the expectations or results that may be achieved.

____5. It has been explained to me that during the course of such operation(s), unforeseen conditions may be revealed which necessitates either an extension of the aforementioned operation(s), or modified procedure(s) other than those listed. I therefore authorize, and do request, that **Faisal A. Quereshy, M.D., D.D.S.,** his assistants or designees, perform such surgical procedure(s) that are necessary and/or desirable in the exercise of professional judgement. The authority granted in this item shall also include treatment of all conditions, which are presently not known to **Faisal A. Quereshy M.D., D.D.S.** but becomes apparent at the time of the operation.

____6. I furthermore know and understand that the quality of bone and the predictability of the success cannot be determined until an attempt is made to prepare the bone.

____7. I understand that excessive smoking and alcohol may affect gum healing and may limit the success of the implant. I agree to follow by doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

I certify that I have had the opportunity to fully read this consent. I have been given the opportunity to ask questions about my condition, alternative forms of treatment and risks of non-treatment, the procedures used, and the risks and hazards involved. I am likewise satisfied that any and all possible alternative methods of treatment have been thoroughly explained. My signature below indicates my agreement and understanding of my proposed treatment and I hereby give my willing consent to the surgery.

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Patient's (or Legal Guardian's) Signature **Date**

Doctor's Signature **Date**

Witness' Signature **Date**