CONSENT FOR ZYGOMATIC and PTERYGOID OSSEOINTEGRATED IMPLANT SURGERY

Patient Name: _____ **Date:** _____

I hereby authorize Dr's. Broumand and his team and staff to perform the following procedure:
Quadruple Zygomatic Implants with possible anterior maxillary implants or pterygoid implants and Mandibular full arch implants with 4 to 6 implants for upper and lower implant retained hybrid restorations.
and to administer the anesthetic I have chosen: ( ) local ( ) intravenous sedation ( ) nitrous oxide( ) general anesthesia.

Other treatment options: Do Nothing at all or wear a complete maxillary and mandibular denture or perform reconstructive surgery with bone grafting for future conventional implants.

PLEASE READ EACH PARAGRAPH. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE SIGNING.

TWO-STAGE OSSEOINTEGRATED IMPLANT SURGERY

1. I hereby authorize Dr.Broumand, and any other agents, assistants, or employees selected by him to treat the condition described as: Maxillary and Mandibular anodontia and Terminal Dentition

2. The procedure necessary to treat the condition has been explained to me and I understand the nature of the procedure to be: Replace all missing Maxillary and/or Mandibular teeth with a fixed bridge

3. I understand incisions will be made inside my mouth for the purpose of placing one or more root form, pterygoid and zygomatic structures (implants) in my jaw to serve as anchors for all my missing upper teeth with a hybrid denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the temporary hybrid denture that will be attached to this implant will be made by Dr._____ and that the Oral Surgery Department and Dr. Broumand are NOT responsible for the final or temporary restorations.

4. I understand that the implant may remain covered by gum tissue for at least four months before it can be used and that a second surgery may be required to uncover the top of the implant.

5. No guarantee can be or been given that the implant(s) will last for a specific time period. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.

6. I have been informed of possible alternative methods of treatment (if any), including: Do Nothing at all or wear a complete maxillary and mandibular denture or perform reconstructive surgery with bone grafting for future conventional implants. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of these choices have been presented to me:

7. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedures and in this specific instance such risks include, but are not limited to, the following:

A. Postoperative discomfort and swelling that may require several days for at-home recuperation.

B. Prolonged or heavy bleeding that may require additional treatment.

C. Injury or damage to adjacent teeth or roots of adjacent teeth.

D. Postoperative infection that may require additional treatment.

E. Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.

F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related stress on the jaw joints (TMJ). Pre-existing symptoms may be worsened.

G. Injury to the nerve branches in the upper and lower jaw resulting in numbness or tingling of the chin, inside and outside of the cheek, gums, or tongue on the operated side. This may persist for several weeks, months or, in rare instances, permanently. In some cases, the implant may need to be removed.

H. Opening into the nose or sinus (a normal chamber above the upper back teeth) or swallowing of foreign bodies or pieces of teeth or bone may also occur requiring additional treatment.

I. If the sinus is intentionally entered (sinus lift procedure with grafting) there will be usually be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.

J. The removal of grafted bone from any donor site has its own potential risks and complications, which have been explained to me.

K. Fracture of the Jaws or Zygoma.

L. Fracture of the jaw, vestibular cortical fenestration, cutaneous fistula, oroantral fistula formation, orbital penetration, orbital injury, dislodgement into the infratemporal fossae, bleeding and temporary sensory nerve deficits are all rare but possible with zygomatic, pterygoid or all on four and five or implant procedures, and <u>implant failure if I use cigarettes or tobacco after surgery for life</u>.

8. It has been explained to me that during the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from those set forth in Paragraph 2 above. I authorize my doctor and his staff to such different procedure(s) as necessary and desirable in the exercise of professional judgment.

9. I consent to the administration of anesthesia in connection with the procedure referred to above. If intravenous anesthesia is used, there may be soreness at the injection site or long to the vein, as well as some bruising around the injection site. In rare cases, vein irritation may cause restricted mobility of the arm or hand and may require additional treatment.

10. I have been made aware that certain medications, drug, anesthetics and prescriptions, which I may be given, can cause drowsiness, uncoordination, and lack of awareness, which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to begin sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me unto I am fully recovered from the effects of the sedation.

11. I understand that I am not to have <u>anything</u> (or have not had anything) by mouth for at least 8 hours before my surgery if undergoing conscious sedation. **<u>TO DO OTHERWISE MAY BE LIFE THREATENING!</u>**

12. It has been explained to me, and I understand, that a perfect result is not, and cannot be guaranteed or warranted. I also agree not to attempt to alter or manipulate the implants or temporary or permanent restorations in any way, shape or form myself as this can result in implant failure and I understand I would be responsible for any failures should I attempt to alter or manipulate the restorations whether temporary or permanent now or in the future.

13. I certify that I speak, read, and write English and have read and fully understand this consent for surgery; and that all blanks were filled in prior to my initialing and signing this form.

14. I am aware the COVID-19 **vaccines** cannot give you **COVID**-19. They are meant to help keep you from getting **COVID**-19 however the FDA and CDC have reported there are adverse events such as formation of clots in the extremities that can occur that can be rarely associated with the COVID-19 vaccine. Please inform us if you have received the COVID-19 vaccine as your risk of developing clots during surgery can be increased.

MISCELLANEOUS

1. I request the disposal by authorities of the below-named medical facility of any tissues or parts, which it may be necessary to remove.

2. I understand photographs and movies may be taken of this operation, and they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

A. The name of the patient and his/her family is not to identify said pictures.

B. Said pictures to be used only for purpose of medical/dental study or research.

FEMALE PATIENTS

I have advised Dr. Broumand, as to whether I am currently utilizing birth control pills. I have been advised and informed certain antibiotics and some pain medications may neutralize the therapeutic effect of birth control pills allowing for conception and resulting in pregnancy. I agree to consult with my family physician to initiate additional forms of mechanical birth control during the period of my treatment with Dr. Broumand and until I am advised I can return to exclusive use of birth control pills by my physician.

I have had an opportunity to have questions answered and I certify that I understand English.

Patient's or legal guardian's signature _____ Date _____

Witness' signature _____ Date _____

Counseling Physician/Dentist: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Physician/Dentist) _____ Date _____