"YOUR PRACTICE NAME HERE"

BISPHOSPHONATE DRUG
INFORMED CONSENT

***The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for elective dental treatment. Each item should be initialed after the patients (and/or their parents or guardians) have the opportunity for discussion and questions*.**

Having been previously treated with Bisphosphonate drugs you should know that there is a risk of future complications associated with dental treatment. Bisphosphonate drugs appear to adversely affect the blood supply to bone, thereby reducing or eliminating its ordinary healing capacity. This risk is increased after surgery, especially from extraction; implant placement or other "invasive" procedure that might cause trauma to bone. Osteonecrosis may result. This is a long term, destructive process in the jawbone that is often difficult to eliminate.

Research has shown that the risk is lower for those having taken oral medications.

_____ **1. I accept and understand that antibiotic therapy may be used to help control possible postoperative infection. For some patients such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.**

_____ **2. I accept and understand that despite all precautions, there may be delayed healing, osteonecrosis, loss of bony and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula, or other significant complications.**

_____ **3. I accept and understand that even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection due to the condition of the bone blood supply.**

_____ **4. I accept and understand that long-term postoperative monitoring may be required and cooperation in keeping scheduled appointments is important. Regular and frequent dental check-ups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.**

_____ **5. I accept and understand that if nothing is done, any of the following, but not exclusive of, could occur:**

> ***Bone disease; Loss of bone; gum tissue inflammation; infection; sensitivity; looseness of teeth, followed by evolution of the tooth; tempromandibular joint problems; headaches; referred pains to the back of the neck and facial muscles; or, tired muscles when chewing.***

_____ **6. I have read the above paragraphs and understand the possible risks of undergoing my planned treatment. I understand and agree to the treatment plan.**

_____ **7. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.**

_____ **8. I realize that, despite all precautions that may be taken to avoid complications; there can be no guarantee as to the result of the proposed treatment.**

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

Patient's Signature (or Parent/Guardian):_____ Date: _____

Patient's (or Parent/Guardian's) Identification: _____

Witness' Name:_____ Witness' Signature:_____ Date:_____

Doctor's Signature: _____ Date: _____