 **Bisphosphonates Medications Informed Consent Form**

**Patient's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**
This consent form is designed to ensure that you fully understand the specific risks, benefits, and potential complications associated with dental implant or bone graft surgery, particularly as they relate to your present or past use of Bisphosphonate Medications. It is important that you read this form carefully, ask any questions you may have, and acknowledge your full understanding and acceptance of these risks.

1. **Risks Specific to Bisphosphonates Medications**

Bisphosphonate Medications are commonly prescribed for conditions such as rheumatoid arthritis, osteoporosis, cancer, and autoimmune diseases. While they are effective in treating these conditions, they can also interfere with bone healing and increase the risk of osteonecrosis of the jaw.

*Increased Risks Include:*

* **Osteonecrosis of the Jaw (ONJ):** A serious condition where the jawbone fails to heal after minor trauma, leading to exposed bone, infection, and chronic pain.
* **Delayed Bone Healing:** The medications can impair bone remodeling and healing, leading to a higher risk of implant failure.
* **Infection:** A compromised healing process can increase the risk of infection at the implant site.
* **Implant Failure:** The impaired healing may prevent the implant from integrating with the bone, necessitating its removal.
1. **Alternative Treatment Options**

Given the risks associated with your medications, alternative treatments to dental implants have been discussed, including:

* No Treatment: Not recommended
* Removable Dentures: Prosthetic devices that do not require surgery and carry no risk of ONJ.
* Fixed Bridges: Supported by adjacent teeth, these do not involve direct placement into the jawbone.
* Delaying Surgery: Postponing the implant procedure until the risk of ONJ has been minimized, possibly by adjusting your medication in consultation with your healthcare provider.

 **Biologic/Monoclonal Antibody Medications Informed Consent Form (cont.)**

1. **Consultation with Your Healthcare Provider**

Before proceeding with dental implant surgery, it is essential to consult with the healthcare provider who manages your biologic or monoclonal antibody therapy. In some clinical situations, your physician may adjust your medication regimen to minimize risks by temporarily discontinuing the medication, altering the dosage, or other measures. However, NEVER alter your medication protocol unless instructed by your physician.

**4. Your Responsibilities**

* Preoperative: You agree to follow preoperative instructions, including consulting with your healthcare provider regarding your medication regimen.
* Postoperative: You commit to adhering to all postoperative care instructions, including attending all follow-up visits.
* Disclosure: You must inform our office of any changes in your medication, health status, or any new symptoms.

**5. Acknowledgment of Understanding**
By signing this form, you acknowledge that:

* I have been informed of the specific risks these medications pose to the success of dental implant surgery.
* I have had the opportunity to ask questions about the procedure, the risks, benefits, and alternative treatments, and all your questions have been answered to your satisfaction.
* I understand that despite the best efforts of the dental team, complications related to these medications may still occur, and there is no guarantee of a successful outcome.

**6. Financial Considerations**

* Costs of Additional Treatments: If complications arise that are specific to these medications, additional treatments or surgeries may be necessary. These treatments may incur additional costs, which will be your responsibility.

**7. Consent to Proceed:** I acknowledge that I understand the risks, benefits, and alternatives, and I accept the potential outcomes associated with use of these medications.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_