

Consent for the Placement of Dental Implants

An explanation of your need for dental implants, their purpose and benefits, the surgeries related to their placement and exposure, and the possible complications as well as alternatives to their use were discussed with you at your consultation. We obtained your verbal consent to undergo the implant surgical treatment planned for you. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

PURPOSE OF IMPLANTS: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

ALTERNATIVE TREATMENT: Reasonable alternatives to implants have been explained to me such as no treatment, removable dentures and/or dental bridges. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

TYPE OF IMPLANT: I am aware that the type of implant to be used on me is one which is placed into the jaw bone; that this is done by first lifting up the gum tissue, preparing a site in the bone, inserting the implant into the bone, and replacing the gum tissue to cover the bone and implant.

SURGICAL PROCEDURES: I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge, or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed. I also understand that sometimes the implant(s) is covered with a bone graft material or a membrane to further enhance healing and that this may necessitate an additional procedure to remove the membrane.

RISKS: Risks related to this surgery include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloring, perforation of the upper jaw sinus or nasal cavity during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth, or chin, jaw joint injuries or associated muscle spasms, bone fractures, and slow healing. Prosthetic risks include, but are not limited to, unsuccessful union of the implant(s) to the jaw bone, and/or stress metal fracture of the implant(s). Risks related to the anesthetics include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness and/or discoloration or blockage along a vein at the injection site.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant(s) will be permanently retained, but because of the uniqueness of every case, long term success cannot be promised. *No refund will be made for failed implants. Furthermore, there will be additional fees if you require additional procedures such as bone grafting after the implant failure. In the event*

of a failed implant and you decide to proceed with another attempt to place a new implant, a separate fee schedule will be discussed.

CONSENT TO UNFORSEEN CONDITIONS: During treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating doctor.

COMPLIANCE WITH NECESSARY FOLLOW-UP AND SELF-CARE: I understand that it is important for me to continue to see my general dentist or prosthodontist. Implants, natural teeth, and appliances must be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted by the dentist. I understand that it is important for me to abide by the specific prescriptions and instructions given by my periodontist. I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth. I agree to report for dental appointments following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

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PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to the placement of dental implant(s) as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of additional teeth or termination of the procedure prior to the completion of all of the extraction/surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Patient's Signature

Date

Patient's Name

Signature of Patient Guardian

Date

Relationship to Patient

Signature of Witness

Date