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Practice Limited to Periodontics and Dental Implants

As an explanation of your need for dental implants, their purpose and benefits, the surgeries related to their placement and exposure, their possible complications, as well as alternatives to their use were discussed with you at your consultation and we obtained your verbal consent to undergo the treatment planned for you. Please read this entire document, which repeats issues we discussed and provide the appropriate signatures on the last page. Please excuse us for this inconvenience and do ask us to clarify anything that you do not understand.

PATIENT CONSENT FOR DENTAL IMPLANTS

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. 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(s) to be used on me is one which is placed into the jawbone; that this is done by first reflecting a flap of gum, preparing a site in the bone, then inserting the implant into the bone and finally covering the bone and implant with the gum flap.

SURGICAL PROCEDURES: I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, 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 is covered with a bone graft material, or membrane to further enhance healing and that this may necessitate an additional procedure to remove the membrane.

RISKS: Risks related to the surgery include, but are not limited to, post surgical infection, bleeding, swelling, pain, facial discoloration, upper jaw sinus, or nasal cavity perforation during the surgery, transient 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 jawbone, stress, or metal fracture of the implant(s). Risks related to the anesthesia include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness, 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 and since the practice of dentistry is not an exact science, long-term success cannot be promised.

CONSENT TO UNFORESEEN 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 the performance of such additional or alternative procedures as may be required by proper dental care in the best judgment of the treating doctor.

DRUG EFFECTS AFTER SURGERY: I have been informed that prescribed medications may cause drowsiness, alone or in combination with alcohol or other sedatives, and I agreed to not drive or operate dangerous machinery within 12 hours of taking any such medication, or if drowsiness occurs. Furthermore, if sedative medications are to be administered during surgery, I will not attempt to drive myself home after the surgery but will arrange to be driven and accompanied home.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the success of the implant(s). I agree to follow instruction related to my own daily care of my mouth. I agree to report to my doctor for regular follow-up examinations as instructed.

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

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed, or any other reasonable alternative treatment, that such a decision is my sole responsibility. I acknowledge that risks related to my non-acceptance of treatment for my problem have been explained to me and include, but are not limited to: dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bone, further gum recession, problems with my bite including pain, spasm, headaches, or problems with my jaw joints or associated musculature.

SECOND OPINION: If any significant doubt, or questionable understanding persists after receiving explanations and reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of dental implants. It has also been suggested that I discuss this entire procedure with another "interested" party such as my spouse, a relative, or close friend, prior to completing my deliberation and decision.

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 consultation and treatment plan presentation by the doctor.

_____ _____

Patient's Signature **Date**

_____ _____

Signature of Witness **Date**

As part of this consent agreement, I give my personal pledge, as a health care professional dedicated to the well-being of my patients, to make every reasonable effort to assure that you receive the best possible care with the least possible risk.

_____ _____

Signature of Doctor **Date**