

Patient's Name _____ DOB _____
Dental Record # _____

*An explanation of the proposed surgery, its purpose and benefits, the procedure used and the possible complications of its use as well as alternative procedures and likely treatment outcomes were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document, which restates issues we discussed and provide the appropriate signature at the end of the document.
Please ask for clarification of anything you do not understand.*

CONSENT FOR DENTAL IMPLANTS

After careful examination of my oral structures, study of my dental and medical history, and possible consultation with other health care providers, my doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

In order to treat my condition, my doctor has recommended the use of root form dental implants. An implant is a titanium structure which is placed into the jaw and into which an abutment is secured and may be restored with a variety of prostheses to include crowns, bridges, and fixed or removable dentures. I understand that the procedure to allow dental implants to be placed requires a surgery to insert the implant(s) into the jawbone. This procedure requires time for healing and has a surgical phase followed by a prosthetic phase.

I understand that a local anesthetic will be administered to me during my treatment and that sedation may be utilized to improve my comfort and anxiety level. My gum tissue will be opened to expose the bone. Holes in which the implants are then placed will be drilled into the jawbone and the implants will be fitted into the bone and held tightly during the healing phase. Care will be taken to avoid any underlying anatomical structures such as nerves, blood vessels, and sinus cavities during implant placement and x-ray films may be taken to aid my surgeon in guiding the location of my implants.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants altogether, my surgeon will make a professional judgment on the management of the situation. The procedure may involve supplemental bone grafts or other types of grafts to build up the bone of my jaw and thereby assist in placement, closure and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened after adequate healing and the stability of the implant will be verified at that time. If the implant appears satisfactory, an attachment (abutment) will be connected to the implant. Plans and procedures to create an implant prosthetic appliance can then proceed.

The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

I understand that some patients do not respond successfully to dental implants and, in such cases, the implant(s) may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the implant surgery, drugs and anesthetics. These complications include, but are not limited to: post-surgical infection, bleeding, swelling, facial discoloration and transient pain. Occasionally, permanent numbness of the lips, tongue, teeth, chin, or gum tissues may occur. Jaw joint injuries or associated transient muscle spasm can occur. On occasion, permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum tissues upon healing may occur. These may result in elongation of the teeth and/or larger spaces between teeth. Cracking or bruising of the corners of the mouth, restricted mouth opening, speech changes,

Initials / Date

allergic reactions, and accidental swallowing of objects have been known to occur. Although these complications are relatively uncommon, the exact duration of any complications cannot be determined and may be irreversible.

I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of any implants that are placed. I further understand that alterations made on the artificial appliances or the implants can lead to the loss of the appliance and/or implant. This loss would be the sole responsibility of the person making such alterations, whether those alterations are made by me myself, a dentist or dental practitioner. The surgeon will not be held liable for any such alterations. I have been advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen during placement, the initial integration of the implant, or anytime thereafter.

Alternative treatments to replace missing teeth may include no treatment, removable and/or fixed appliances where applicable. I understand that these treatments may result in additional bone and soft tissue loss and damage and **will make** implant treatment in the future **unlikely**.

I understand that it is important for me to continue to see my restorative dentist. Implants, natural teeth, and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given to me by my doctor.

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a doctor cannot predict the certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of present condition, including the possible loss of the implant or other teeth, despite the best of care.

I authorize photos, slides, x-ray films, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for educational purposes. My identity will not be revealed to the general public, however, without my express permission.

I have been fully informed of the nature of dental implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available and the necessity for follow-up care and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during consultation and in the treatment plan presentation as described in this document.

I also consent to the use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my dentist's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the bone of my jaw and thereby to assist in placement, closure and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Patient/Guardian Signature

Date

Patient's/**Guardian's** name (please print)

Signature of Witness

Date

Witness's name (please print)

Surgeon's Signature

Date

Surgeon's name (please print)