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IMPLANT SURGERY CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the implant surgical procedure. I understand what is necessary to accomplish the placement of implants under the gum and into the jawbone.
2. If necessary, I have been informed of the need for bone grafting to make the jaw large enough to accommodate the implants or to graft the floor of the sinus for the same reason. I have been informed of the possible reduced success rate that these procedures may entail. I have also been informed of the possible risks involved with the use of natural and artificial bone grafts, as well as the possible advantages that may be achieved with the added use of blood concentrate.
3. My doctor has carefully examined my mouth. Alternatives to implant therapy have been explained and I have chosen the treatment plan involving implant placement and restoration.
4. I understand that if nothing is done, any of the following could occur: continued periodontal disease, loss of bone, infection, sensitivity, looseness of teeth, and the necessity of extraction.
5. I have further been informed of the possible risks and complications that may occur during or following bone grafting/implant surgery, anesthesia, and drug use. Such complications include, but may not be limited to, pain, swelling, discoloration, and infection. Numbness of the lip, tongue, cheek, chin, or teeth may occur. This most often is temporary, however it may be permanent. Also possible are inflammation of a vein, injury to adjacent teeth, bone fractures, sinus inflammation, delayed healing, and allergic reactions to drugs or medications.
6. I have been advised that there is no way to accurately predict the soft tissue and bone healing capability of each individual patient following the placement of a bone graft or dental implant.
7. I have been advised that, in some instances, implants fail and must be removed. This failure can occur at any time after the implant is place, even after the replacement teeth have been made. I have been informed that the practice of dentistry is not an exact science: no guarantees or assurances as to the outcome or results of treatment or surgery can be made.
8. I understand that it has been statistically shown that excessive smoking increases the risk of implant failure. Excessive alcohol consumption and uncontrolled diabetes (sugar) also increase this risk. Use of a bite guard is mandatory for patients with grinding or clenching habits. I agree to report for regular follow-up examinations as instructed.
9. I agree to the type of anesthesia that has been recommended by my dentist. I agree not to operate a motor vehicle or other hazardous device for at least 24

hours, or until fully recovered, from the effects of drugs or anesthesia used for my care.

10. I understand that, after surgery has been completed, I will be returned to my referring dentist for the fabrication of the prosthetic (tooth replacement) appliance. I further understand that there will be a separate fee to my dentist for the fabrication of the prosthetic (tooth replacement) appliance and that this is not a part of the surgical fee. Any prosthetic fee given by this office should be considered as an estimate. This fee will be determined by your referring dentist and may be altered by changes in the surgical or prosthetic treatment plan or by esthetic demands.

    Patient initials for #10 above_____

11. The design and structure of the prosthetic appliance can be an important factor in the success or failure of an implant. Alterations made to this appliance (crown, bridge, denture) can lead to the loss of the appliance and/or implants. This loss would be the sole responsibility of the person(s) making such alterations.
12. I understand that implants, teeth, and prosthetic appliances require maintenance care and that it is my responsibility to have this care performed as I am directed. Failure to do so can lead to premature loss of implants and prosthetic appliances or to the need for additional treatment.
13. To the best of my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, gum or skin reactions, blood or body diseases, abnormal bleeding, or other conditions relating to my health. I have reported any disease condition that, to my knowledge may make bone grafting/implant treatment inappropriate due to poor healing capacity or diminished life expectancy.
14. I consent to photography, filming, recording, and x-rays of the procedures to be performed for patient records and the advancement of implant dentistry (teaching purposes) provided my identity is not revealed.
15. I have been given the opportunity to ask questions regarding treatment and outcomes and these questions have been answered to my satisfaction.

16. I request and authorize medical/dental services for me, including, extractions, bone grafts, sinus grafts, implant placement, periodontal procedures and other treatment as required to complete my proposed treatment plan. I fully understand that during and following the contemplated surgery or procedures conditions may become apparent which warrant, in the judgment of my implant surgeon, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials or care if it is felt that this is for my best interest.

I certify that I have read and fully understand this document

_____
Printed name of patient

_____ _____
Patient signature Date

_____ _____
Surgeon signature Witness signature