



CONSENT FOR IMPLANT SURGERY

Patient's Name: _____

1. I have been informed and afforded the time to fully understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant in the bone, under the gums.
2. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire implant(s) to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include: pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur, of which the exact duration may not be determinable; numbness may also be irreversible. Also possible are thrombophlebitis (inflammation of a vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc. The metals used in the implants and the healing attachments are: titanium (90%), aluminum (6%) and vanadium (4%), so I am aware that any allergy to these would be a contraindication for implant placement.
4. I understand that scuba diving or snorkeling is prohibited for the first 6 months after implant surgery.
5. I understand that if nothing is done, any of the following could occur: loss of bone (under gums), gum inflammation, infection, sensitivity, and fracture and/or looseness of teeth followed by necessity of extraction. Also possible are: temporomandibular (jaw) joint problems, headaches, referred pain to the back of the neck and/or facial muscles, tired muscles when chewing, and difficulty in functioning with a denture. In addition, I am aware that if nothing is done, an inability to place implants at a later date, due to changes in oral or medical conditions, could exist.
6. I understand that there is no method to accurately predict the gum and the bone healing capabilities in an individual patient, following the placement of the implant(s).
7. It has been explained that, in some instances, implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of the results of treatment or surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further, corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.

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8. I understand that excessive smoking, alcohol or blood sugar may affect gum healing and may limit the success of the implant(s). I agree to follow my doctor's home care instructions precisely. I agree to report to my doctor for regular examinations as instructed.
9. I agree to the type of anesthesia chosen by the doctor. I agree not to operate a motor vehicle or hazardous device until fully recovered from the effects of the anesthesia or drugs given for my care.
10. To my knowledge, I have given an accurate report of my physical health and social history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites or anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
11. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, providing my identity is not revealed.
12. I request and authorize medical/dental services for myself (or my child), including implant(s) and other surgery as discussed. I fully understand the contemplated procedure, surgery or treatment conditions that may become apparent which warrant, in the judgment of the doctor, 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/the patient's best interest. If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, associate or assistant to do whatever he/she deems necessary and advisable under the circumstances, including the decision not to proceed with the surgery.

Signature of Patient or Guardian

Date

Signature of Witness

Date

Signature of Doctor

Date