

## CONSENT FOR DENTAL IMPLANTS

Description of Procedure: Placement of implants

**IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING OR SIGNING THIS FORM.**

\_\_\_\_ 1. I have been informed and understand the purpose and nature of my implant surgery procedure. I understand what is necessary to accomplish the placement of the implant into my jawbone.

\_\_\_\_ 2. My mouth has been carefully examined. Alternatives to this treatment have been explained. I have tried or considered these methods, but desire an implant as a means to help secure the replacement of missing teeth.

\_\_\_\_ 3. I have further been informed of the possible risks and complications involved with my gum surgery. Such complications that may occur include pain, swelling, infection, bruising, numbness of the lip, tongue, chin, cheek or teeth, an alteration in taste, injury to teeth, bone fractures, sinus penetration, and delayed healing.

\_\_\_\_ 4. I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, looseness or drifting of teeth followed by necessity of extraction. Also possible are temporomandibular joint (TMJ) problems.

\_\_\_\_ 5. It has been explained to me that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of implants.

\_\_\_\_ 6. It has been explained that, in some instances, implants fail and must be removed. I understand that sometimes implants are placed and not used. I understand if implants are lost, they can usually be replaced after the bone heals. There can also be bone loss with the failure of an implant.

\_\_\_\_ 7. I have been informed and understand that the practice of dentistry is not an exact science; neither guarantees nor assurances as to the outcome or results of treatment or surgery can be made.

\_\_\_\_ 8. I understand that excessive smoking, use of alcohol, or sugar may affect gum healing and may limit the success of my implant. I agree to follow my doctor's home care instructions and report to my dentist for regular examinations as instructed. I realize that my own proper oral hygiene is critical to the future success of my implant and that I must maintain good oral hygiene. Like normal dentition, implants may be affected by lack of oral hygiene and can actually be lost due to neglect.

\_\_\_\_ 9. My surgical implant care may involve two stages: the first for installation of the fixture to my jawbone, and the second for the uncovering of the fixture, so that an abutment can be connected to the implant. The abutment projects from the top of the implant through the gum tissue, into my mouth.

\_\_\_\_ 10. I am aware that occasionally speech can be affected by the placement of implants. I am aware that further soft tissue surgery is sometimes necessary to improve the relationship of the soft tissue to the implant. I am also aware that the implant might be visible.

\_\_\_\_ 11. I agree to the type of anesthesia—local or general—administered intravenously, intramuscularly, orally or by inhalation. I agree not to operate a motor vehicle or hazardous device for at least 24 hours (or more) until I am fully recovered from the effects of the anesthesia or drugs given for my care. I am aware that possible anesthesia risks include inflammation of veins and allergic reactions caused by my drugs or medications.

\_\_\_\_ 12. To my knowledge, I have given an accurate report of my physical and mental health history, including any prior allergic or unusual reaction to drugs, food, insect bites, anesthetics, pollens, dust, abnormal bleeding, or any other condition.

\_\_\_\_ 13. I consent to photography, filming, recording and X-rays of the procedure to be performed for the advancement of implant dentistry.

\_\_\_\_ 14. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent that warrant—in the judgment of my doctor—additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials or care if it is felt to be in my best interest.

\_\_\_\_ 15. I am satisfied that I have had the opportunity to ask all my questions and that I understand all the terms of this agreement.

### **INFORMATION FOR FEMALE PATIENTS**

- I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

### **CONSENT**

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have and the risks of those choices have been presented to me. I have read and understand the above and give my consent to surgery and chosen anesthesia. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.