

Provider: Dr Ash

CONSENT FOR DENTAL IMPLANT SURGERY

Patient's Name _____

Date _____

During your consultation we discussed your need for root form dental implant(s), steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure. **Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page.**

_____ 1. My planned procedure will involve placement of _____ implant(s) in the following area:

Upper Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Left	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Lower Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Left	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

_____ 2. I understand that dental implants may be placed by either a one-stage technique or two-stage technique. One stage means the implant will be surgically positioned with a portion of the implant protruding through your gum tissue at the completion of surgery. Two-stage surgery requires one surgery to place the implant, followed by a healing time, then a second surgery to uncover the implant and place a healing cap that protrudes through the gum tissue. Both the one-stage and two-stage implant placement technique usually requires a healing period before your restorative dentist will be able to place a dental restoration (crown, bridge or denture). Your surgeon and restorative dentist will use the technique that is best suited for your condition.

_____ 3. In certain unusual circumstances, and with very specific criteria, your surgeon and restoring dentist may elect to restore the implants immediately or shortly after the placement procedure. This "Immediate Load" technique presents some increased concerns about bone and implant healing.

_____ 4. In certain cases, the surgery may involve additional materials and procedures (grafting with bone or artificial bone substitutes, use of healing membranes and associated fixation devices, impressions or indexing the implants, etc.). The need for those procedures may not be apparent until after the surgery has begun.

_____ 5. Your procedure is intended to be: One stage Two stage Immediate Load

_____ 6. The possible alternative methods (if any) of replacing my missing teeth have been explained to me, including [All the options below include the risk of slow but progressive resorption (dissolution) of the underlying (supporting) jawbone, the correction of which may be difficult and costly]:

- A. No Treatment
- B. Keeping or attempting to improve my present denture or bridge
- C. Restoring missing teeth with "conventional" methods, such as a fixed bridge or removable partial denture if feasible.

_____ 7. I understand that incisions will be made inside my mouth for the purpose of placing one or more root-form structures (dental implants) in my jaw to serve as anchors to replace a missing tooth or teeth, upon which a crown (cap), bridge or denture will be secured. I acknowledge that the procedure has been explained to my full understanding, including the number and location of incisions and the type of implant(s) that will be used.

_____ 8. I understand that the dental restoration (such a crown, bridge or denture) will be made and placed by Dr. _____, and that a separate charge for such services will be made by that doctor. That doctor will also monitor those restorations in the future.

_____ 9. I understand that if a **two-stage** procedure is planned, the implant will probably remain covered by gum tissue for the initial healing period, and that second surgical procedure will be required to uncover the top of the implant to prepare for a dental restoration. In a one-stage procedure, the implant will usually remain accessible).

10. Risks and Complications of Dental Implant Surgery include, but are not limited to:

- _____ A. Post-operative discomfort, swelling and bruising that may require several days of at-home recovery.
- _____ B. Prolonged or heavy bleeding that may require additional treatment.
- _____ C. Damage to adjacent teeth or roots of adjacent teeth.
- _____ D. Post-operative infection that may require additional treatment.
- _____ E. Stretching of the corners of the mouth that may cause cracking and bruising.
- _____ F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

_____ G. Injury to nerve branches in the jaw or soft tissue resulting in tingling, numbness, or pain in the chin, lips, cheek, gums, tongue (including possible loss of taste sensation) or teeth on the operated side(s). These symptoms may persist for several weeks or months, and in some cases may be permanent (very rare).

_____ H. Opening into the sinus (a normal hollow chamber in the bone above the roots of back upper teeth) requiring additional treatment. If the sinus is entered, there may be symptoms of sinusitis for several weeks that may require certain medications and additional recovery time.

_____ I. Fracture of the jaw or of thin bony plates.

_____ J. Bone loss around the implants.

_____ K. Certain other fixation devices may be used (screws, plates, membranes, etc.) that may either stay in place permanently or require later removal by another surgery. There may be unexpected exposure of these devices through the gum, causing their premature loss or removal, and possible loss of the implant.

_____ L. Implant or prosthesis failure. Rarely, the implant or parts of the structure holding the replacement tooth, or the replacement tooth itself, may fail due to chewing stresses.

_____ M. Rejection of the implant by natural body defenses. (If the implant is lost, it is usually possible to replace it in a later surgery after the bony defect has healed or been bone grafted to achieve adequate bone volume for another implant placement procedure.)

_____ 11. It has been explained to me that during the course the surgery unforeseen conditions may be revealed that will necessitate extension of the original procedure or a different procedure from that which was planned (for example, changing from a one-stage to a two-stage process, use of bone grafting techniques involving substitute material or locally available bone particles, etc.). I further understand that if during surgery, clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my doctor will make a professional judgment on the management of the situation. The procedure may need to be cancelled. I give my permission for such addition procedures that may be indicated in my doctor's professional judgment.

_____ 12. No guarantee can be or has been given that implant(s) will last for a specific time period. It is anticipated that the proposed treatment will be successful and enhance my dental health. Nonetheless, it is not possible to predict the absolute certainty of success. Implants have a success rate of 90-95%. This success rate is lower in smokers. Situations where bone grafting or sinus elevation grafting must be performed also have lower success rates. I acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eliminating all pre-treatment symptoms or complaints. I acknowledge that there is the risk of failure, relapse, selective re-treatment, or worsening of my present condition, despite efforts at optimal care.

_____ 13. I understand that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If the planned schedule is not carried out, the implant(s) may fail.

_____ 14. I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in this procedure.

_____ 15. I understand tobacco use is extremely detrimental to the success of implant surgery. Implants have a success rate of 90-95%. This success rate is lower in smokers I agree to cease all use of tobacco (including e-cigarettes) for 2-3 weeks prior to and after surgery, including the later uncovering procedure, and to make strong efforts to give up smoking entirely.

_____ 16. **Use of Records for Reimbursement and Publication Purposes.** I authorize photos, video recordings, x-rays, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will never be revealed to the general public.

_____ 17. **Females only.** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the root from dental implant 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 periodontist. After thorough deliberation, I hereby consent to the root from dental implant surgery as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document

Patient's Signature (or patient's guardian) Date

Witness Signature Date