

IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum and in the bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have considered these methods, but I desire an implant 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. The exact duration may not be determined and may be irreversible. Also possible are: injury to teeth, bone fracture, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done, and have the following could occur: Loss of bone, tipping or extrusion of teeth, looseness of the teeth, followed by the necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, and referred pains to the back, neck, and facial muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and bone before surgery. I understand that during and following the contemplated surgery or treatment; conditions may become apparent which warrant, in the judgement of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. Sometimes the implant cannot be placed, or it is indicated to place one or more additional implants. Fees will be adjusted according to the change in time and materials utilized.
6. It has been explained that healing capabilities in each patient following implant placement vary. 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 as to the outcome of treatment or surgery can be made.
7. I understand that smoking or alcohol usage may affect gum healing and may limit the success of the implant. I agree to follow home care instructions. I agree to report to my doctor for regular examinations and cleanings as requested.
8. I agree to the type of anesthesia, depending on the choice by the doctor. I agree not to operate a motor vehicle or hazardous device for at least 12 hours or more until I have fully recovered from the effects of the anesthesia or drugs given for my care.
9. To 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, anesthetics, etc., or abnormal bleeding or any other conditions related to my health.
10. I consent to photography, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

Date

Signature of Patient, Parent or Legal Guardian