

PATIENT'S CONSENT FOR DENTAL IMPLANT SURGERY

Name _____ Date ____/____/____ Tooth _____

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

EXPLANATION OF DIAGNOSIS: I have been recommended to receive a dental implant to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

RECOMMENDED TREATMENT: A dental implant or implants will be placed into the jawbone during a surgical procedure. Each will be placed by reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone and then covering the bone and implant with gum flap.

MULTIPLE PROCEDURES: I understand that multiple surgeries are necessary: first, to insert the implant(s) as described above, and second, to uncover the top of the implant(s) so that it may be exposed and used for attachment of a tooth, bridge or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site, either prior to implant placement or after the implant(s) have healed. I also understand that sometimes the implant is covered with a bone graft material or membrane to further enhance healing and that this may necessitate an additional procedure.

PRINCIPLE RISKS AND COMPLICATIONS: Risks related to dental implant surgery may include but are not limited to: post-surgical infection, bleeding, swelling, pain, facial discoloration, upper jaw, sinus or nasal cavity perforation during surgery, transient or possibly permanent numbness of the lip, tongue, teeth, chin, or gum; jaw joint injury or associated muscle spasms, bone fractures, and slow healing. Prosthetic risks include but are not limited to unsuccessful union of the implant(s) to the jawbone and stress metal fracture of the implant(s). If any of these occur, a separate surgical procedure will be necessary to remove the failed implant(s). Risks related to anesthetic may include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness, or discoloration at the site of the anesthetic injection.

I acknowledge the success of treatment may be affected by medical conditions, dietary and nutritional problems, smoking, alcohol intake, clenching and grinding of teeth, inadequate oral hygiene, and medications I may be taking. To my knowledge, I have reported any prior drug reactions, allergies, diseases, symptoms, habits or conditions to the doctor that may relate to this surgical procedure.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either as proposed or another reasonable alternative, such a decision is my sole responsibility. I acknowledge that the risks related to my non-acceptance of treatment for my condition have been explained to me and include but are not limited to dissatisfaction with or failure of other forms of tooth replacement, further deterioration of jawbone, further gum recession, problems with my bite including pain, spasm, and headaches, or problems with my jaw joints and associated musculature.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed implant(s) will be completely successful in function and appearance (to my complete satisfaction). It is anticipated that the implant(s) will be permanently retained; however, due to individual patient differences, one cannot predict the absolute certainty of success.

Initials: _____

CONSENT TO UNFORSEEN CONDITIONS: Unforeseen conditions may be discovered during surgery such as a changed prognosis for adjacent teeth or insufficient bone support for the implant(s) that call for a modification or termination of the procedure prior to completion of the scheduled surgical plan. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that smoking and/or alcohol intake may affect gum healing and may adversely affect the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth and the use of prescribed medications. I agree to report for appointments following my surgery so the doctor may monitor my healing, evaluate and report the outcome of surgery, and if necessary, adjust prosthetic appliances. I also understand that since existing restorative dentistry is an important factor in my healing and ongoing care, it is important for me to see my regular dentist as recommended.

RESPONSIBILITY FOR PROSTHETIC SUCCESS: I understand that the fabrication and attachment of prosthetic devices (tooth replacements) will be the responsibility of another dentist and that the long-term maintenance, repair and success of these devices will be the sole responsibility of the dentist who provides this prosthetic care.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed without my permission.

PATIENT'S ENDORSEMENT: My endorsement (signature) on this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of all procedures related to dental implant surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Signature _____
Patient / Responsible party

Date ____/____/____

Print name

Relationship _____
to patient

Signature of witness

Date ____/____/____