CONSENT FOR DENTAL IMPLANTS

t DIAGNOSIS

After a careful oral examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

RECOMMENDED TREATMENT

In order to treat my condition, the doctor has recommended the use of root form dental implants. I understand that the procedure for root form implants involves pladng Implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.

SURGICAL PHASE

I understand that sedation may be utilized and that a local **anesthetic will be** administered to me **as part of** the treatment. My gum tissue will be opened to expose the bone. Implants will be placed by tapping **or** threading them into holes that have been dnlled In **my** jawbone. **The gum** and soft tissue will be stitched dosed over **or** around the **implants.** Healing will be allowed **to proceed for a period** of four to six months. I understand **that** dentures usually cannot be worn during **the** first one to two weeks **of healing.**

I further understand that **dinical conditions** may turn out to be unfavorable for **the** use of **this** implant system or prevent the **placement of implants. If dinical conditions prevent the placement of implants, I defer** to **the doctor's judgment on the** surgical management **of the situation,** to **indude** the use **of bone** grafts **and regenerative membranes.**

For **implants** requiring **a second** surgical **procedure, the overlying tissue will** be **opened at the appropriate time, and the** stability **of the implant will** be **verified. If the implant** appears **satisfactory, an attachment will be connected** to **the implant.**

I have been informed that smoking habit adversely influences **the success of any implant procedure.**

I EXPECTED BENEFiTS

The purpose of dental implants is to allow **me to have more functional artificial teeth. The implants provide support,** anchorage, **and retention** for these **teeth.**

PRINCIPLE RISKS **AND COMPLICATIONS**

I understand that some **patients do** not respond successfully **to dental implants, and in such cases, implants** may **be lost. Implant surgery may** not be successful in providing artificial **teeth. Because each patient's condition is unique, long-term success may not** occur **and is not guaranteed.**

I understand that complications may result from **the implant surgery, drugs, and** anesthetics. **These complications indude,** but **are not limited to:** post-surgical **infection, bleeding, swelling** and **pain, facial discoloration, transient but on** occasion **permanent numbness of the lip, tongue,** teeth, **chin or gum, jaw joint injuries or** associated **muscle spasm, tooth** sensitivity **to hot, cold sweet or acidic foods,** shrinkage **of the gum upon healing** resulting **in elongation of some teeth and** greater spaces between some teeth, craddng **or** bruising of **the** corners **of the** mouth, restricted ability to open **the** mouth **for** several days, **or** weeks, impact **on** speech, injury to teeth, bone fractures, nasal **sinus** penetrations, **delayed healing, and** accidental **swallowing of foreign matter. The exact** duration **of any complication** cannot **be determined, and** they **may be** irreversible.

I understand that the design and structure **of** the prosthetic appliance can be a substantial factor **in the** success **or failure of the implant from** both a functional **and** esthetic standpoint. **The** esthetic **limitations** should **be fully** discussed with your general dentist or prosthodontist before **the case is** initiated.

CONTINUED ON ThE REVERSE **SIDE**
PLEASE READ AND SIGN
Consent: Dental Implants
Rev.1/2000

ALTERNATIVES **TO SUGGESTED** TREATMENT
Aftemative treatments for missing teeth **may indude: no treatment,** fabrication **of** new **removable** appliances **or** bridges.

NECS'RY FOLLOW-UP CARE AND SELF-CARE
I understand that it is important for me to continue to see the doctor **who is** performing the implant surgery **and my** family dentist for **follow-up. Implants, like** natural teeth, need **to** be deaned daily **and** adjustments **are** required periodically.

I **NO** WARRANTY **OR** GUARANTEE 1
I hereby acknowledge that **no guarantee, warranty or** assurance has been **give to me that the** proposed **treatment Will be** successful. There **edts the risk of** failure, need for additional **treatment, the need** for endodontic treatment **on adjacent teeth** despite the best of care.

PUBLICATION OF RECORDS
I authorize **slides, and** x-rays **of my case to be** used **for** advanced **education. My** identity **will** not be revealed **to the general public** without **my permission.**
I have been fully **informed of the nature of implant** surgery, **the** procedure to **be utilized, the risks and the benefits, alternative treatments, and the necessity of follow-up care. I have had the** opportunity to ask **questions I may have in** connection with treatment **and to** discuss **them with the doctor.** After **thorough deliberation, I** hereby **consent to** performance **of dental implant** surgery.
PROCEDURE _____
Patient Signature Date
Witness Signature _**Date**
Consent: Dental Implants
Rev. 1/2000