Implant Patient Information and Consent Form

I have been informed and I understand the purpose and the nature of the dental implant surgery procedure. I understand what is necessary to accomplish the placement of implants into the bone.

1. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried, or considered these methods, but I desire dental implants.
2. 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 determinable and may be irreversible. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reactions to drugs or medications used, etc.
3. I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, and nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
4. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of implants.
5. It has been explained that 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 or assurances as to the outcome of treatment or surgery can be made.
6. I understand that extensive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implants. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
7. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until recovered from the effects of the anesthesia or drugs given for my care.
8. 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, food, insect bites, anesthetics, pollen, dust, blood, or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
9. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
10. 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 which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

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Signature of Doctor Date

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Signature of Patient/Guardian Date

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Witness Date

Bone Graft Informed Consent

I ____________________________, understand that when a tooth is extracted, the underlying bone tends to atrophy (shrink). Bone grafting is a method to reduce or offset this bone atrophy after extraction(s), or to supplement bone around an implant, in a large sinus cavity, or to treat pocketing around a tooth. Listed below are several types of bone grafting materials/techniques for you to select from.

Please indicate your preference by initialing beside your selection:

____ **Self** (Autogenous) graft: transplants or grafts your own harvested bone, either small particles or in block form, for jaw rebuilding - very effective but harvesting your bone is more painful and expensive.

____ **Donor Human** (Allograft) OR **Donor Bovine** (cow) graft: pre-packaged cadaver bone particles - very effective and reasonable cost, but there exists a rare risk of disease (estimated currently at less than 1 occurrence out of every two million uses), and will preclude blood/tissue donations for 1 year or more at most blood banks.

____ **Synthetic** (Alloplast) graft: places synthetic/chemically derived bone substitutes - less effective but no risk of disease transmission.

Please read carefully and ask your surgeon if you have questions regarding any of the following:

1. I have been informed, and I understand the purpose, of the bone graft procedure.
2. I understand that there may be risks and complications of any procedure including swelling, bruising, pain, bleeding, infection, altered sensation (usually numbness at the donor site), allergic reaction or other adverse reactions to medications or materials used during or after the procedure.
3. I understand that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft; and that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.
4. It has been explained to me that, in rare instances, bone grafts fail and must be removed. Lack of adequate bone growth into the bone graft replacement material could result in failure. No assurances or guarantees as to the outcome of the results of treatment or surgery can be made. I am aware that should the bone graft surgery fail, it may require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. Should the bone graft surgery fail, I understand that alternative non-surgical prosthetic measures may have to be considered.
5. I understand that smoking or high blood sugar (diabetes) may effect gum healing and may limit the success of the bone graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
6. To my knowledge, I have given an accurate report of my health history. I have also reported any unusual reaction to drugs, anesthetics, food, insect bites, pollen or dust, any blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
7. I request and authorize medical/dental services for me, including bone grafts and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve of modifications in design, materials, or care, if it is felt this is for my best interest, including the decision not to proceed with the bone graft.

I have reviewed the above information, and have had the opportunity to have any questions/concerns addressed. Based on the information presented by my doctor(s) regarding my diagnosis, the proposed treatment, the treatment alternatives, and the associated risks and complications of such treatment, I request that you perform the planned surgical treatment.

Patient/Parent Signature **Date** **Witness**

Doctor Signature **Date**

SROS #101-1SW