

IMPLANT INFORMATION AND CONSENT FORM

1. My doctor has carefully examined my mouth and has recommended a dental implant procedure. I fully understand that failure to secure some form of treatment for my existing condition could lead to further complications. I have tried or considered alternative treatments and procedures, but after careful consideration, I request an implant(s) to aid in securing the teeth to be replaced. ()
2. I have been informed of the potential risks and complications inherent with surgery, drugs and anesthesia required for the insertion of implants. I am aware that complications, including but not limited to pain, swelling, infection and discoloration may occur. I am aware that if bone expansion is required for the placement of any implant(s), numbness of the lip, cheek or teeth may occur. Other possible medical risks include inflammation of veins, injury to the teeth present, bone fracture, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. The exact duration of these or other complications may not be determinable prior to the treatment. ()
3. Bone grafting, ridge augmentation or soft tissue grafts may be needed to complete the implant(s). These products are collected from volunteer donors whose legal next-of-kin have given written consent for the donation. Each individual donor's history is carefully reviewed to reduce the possibility of disease transmission and ensure product integrity. These products are made from donors found non-reactive to serological tests for hepatitis B surface antigen, HTLV-III antibody and syphilis. These products may be used in any situation where the doctor believes that a bone and/or soft tissue procedure will promote healing or facilitate applicable surgical procedures. These products have been determined to be properly prepared in accordance with the current requirements of the FDA. ()
4. My doctor has advised me that there is no method to accurately predict the tissue and bone healing capabilities in an individual patient prior to or following the placement of an implant. ()
5. I understand that the practice of dentistry is not an exact science. I have been informed that in some instances implants fail. No guarantee or assurance as to the outcome of the results of treatment can be, or is being made. I further acknowledge that the list of possible complications, of which I have been advised, is not intended to be, nor do I consider it to be complete. ()
6. The doctor has specifically advised me of the consequences of SMOKING during the course of my implant procedure. I have been advised that I MUST refrain from smoking a minimum of 48 hours before treatment and abstain from all forms of tobacco products until the doctor advises me that healing is complete. Failure on my part to follow these recommendations could result in serious complications including possible infection, necrosis (destruction) of tissue, and loss of implants and /or bone graft. ()
7. I agree to carefully follow my doctor's homecare instructions in regard to the use of tobacco and all other directions prior to, during, and following my treatment. I agree to return to my doctor for regular examinations and treatment as instructed and to immediately advise him of any adverse reactions or symptoms. ()
8. I agree to the use of the type of anesthesia determined to be the most suitable by my doctor. I acknowledge that I should not operate a motor vehicle, machinery or any hazardous device for a minimum of 24 hours or until fully recovered from the effects of the anesthesia or drugs prescribed. I am aware that the taking of any other drug, of whatever nature, in combination with the drugs prescribed by my doctor, for the implant procedure, might cause an adverse reaction. Therefore, I agree to refrain from the taking of any other drug or medication whether or not prescribed by another doctor, purchased over the counter, or secured by me in any manner, without the consultation with my doctor. ()

9. I have given my doctors a report of my physical and mental history including my use of any drug (including alcohol). I have advised him of any allergic reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my health. I acknowledge that the doctor has relied on my representations as to my health and has used this information in determining the course of my treatment and that I have fully disclosed my medical history. ()

10. I consent to the photographing, filming, recording and x-raying of the procedure to be performed and authorize their use by the doctor in any manner deemed appropriate by him, for the advancement of implant dentistry, provided my identity is not revealed. ()

11. I therefore consent and authorize the doctor to proceed with my treatment including the insertion of implants and other required surgery. I fully understand that during and following the contemplated procedure other medical conditions may become apparent. They may in judgment of my doctor, warrant additional or alternative procedures relating to the overall success of my treatment. I therefore authorize any modifications in design, materials or treatment plan that the doctor determines to be necessary. ()

12. The doctor has explained, in plain language, what is required for my treatment and the medical risks involved accomplishing the placement of an implant(s) beneath the tissue or into the bone. Having been so, advised I consider the procedure to be appropriate and of a nature consistent with my informed consent, which I hereby give. ()

Signature of Patient (or responsible party)

Date

Signature of Doctor

Date