DENTAL IMPLANT INFORMED CONSENT

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_____ _____
Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor is available to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: _____

Procedure: _____

Alternative options: _____

If a crown, bridge, or denture is to be attached to the implant(s), this will be done by Dr.:

_____

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
    - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
    - Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment
    - An opening may occur from the mouth into the nasal or sinus cavities;
    - Inability to place the implant due to the local anatomy, insufficient bone volume, or bone quality that will not support the implant;
    - Implant failure;
    - Discoloration and appearance changes of the gum tissue;
    - Unsatisfactory functional and/or cosmetic result;
    - Bone reduction or irreversible bone loss;

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- Bone loss around the implant(s) and/or adjacent teeth;
- I understand that bone grafting may be necessary.

GRAFT/SINUS LIFT

The graft will be taken from (anatomic location) or will be banked bone or bone substitute:
_____

The graft will be placed: _____

I understand this graft involves additional potential risks, including but not limited to:

- Nerve injury at the place the graft was taken from or where the graft is placed resulting in altered or loss of sensation, numbness, pain, or changed feeling in the lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
- Failure, loss, infection, or rejection of the graft or membranes used to contain the graft;
- An opening may occur from the mouth into the nasal or sinus cavities;
- If I have elected a banked bone or bone substitute graft, I understand there is a rare chance of disease transmission from the processed bone.

2. I have elected to proceed with the anesthesia(s) indicated below.

_____ Local Anesthesia

_____ Nitrous Oxide (Laughing Gas)

_____ Mild Sedation

_____ Moderate Sedation

_____ Deep Sedation (General Anesthesia)

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is completed;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;

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- Sore throat or hoarseness if a breathing tube is used.

If I have elected Mild, Moderate, or Deep Sedation (General Anesthesia), I have not had anything to eat or drink for at least six (6) hours prior to my procedure. I understand that doing otherwise may be life-threatening. As instructed, I have taken my regular medications (blood pressure medications, antibiotics, etc.) and/or any medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the doctor's office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

3. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

4. Patient's Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care.

I understand and accept the use of tobacco and alcohol is detrimental to the success of my treatment and will comply with my doctor's instructions. I further understand that health factors and tobacco use can significantly affect the rate of healing of a dental implant and may lead to implant failure.

I understand that, dependent on my specific treatment plan:

- The implant(s) may remain covered by gum tissue for an initial healing period and a second surgical procedure will be required to uncover the top of the implant to prepare it for a dental restoration; OR

- The implant(s) may be immediately covered with a temporary or permanent dental restoration, and in some cases, this immediate type of restoration carries an increased risk of failure of the implant.

I further understand that:

- The decision to immediately place a restoration or not may change during the surgical procedure, based on the quality of bone, anatomy or other factors.

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- Because my treatment plan may be altered during surgery, I may not leave the office with a permanent or immediate solution to replace my teeth.

I understand that dental implants fail. I further understand that this risk increases if I am noncompliant with the long-term maintenance, follow up and oral hygiene responsibilities.

I understand that I may be required to alter my diet and avoid hard, sticky, chewy, spicy, acidic and/or high temperature foods.

I understand that I may need to obtain care with additional dental providers, based on my treatment plan and any adjustments needed for my prosthesis.

I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

I understand and accept that the doctor cannot guarantee the results of the procedure or the length of time needed to complete my treatment. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____ _____
Patient or Legal Representative Signature Date

_____
Print Patient or Legal Representative Name/Relationship

_____ _____
Witness to Patient Signature Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_____ _____
Doctor Signature Date