

Dental Implant Consent Form/Oral Surgery Consent Form

All patients receiving dental implants and other oral surgery will be asked to sign consent forms. We've included the text of our consent forms so you can review their contents before coming in to the office.

Dental Implant Consent Form

1. ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires that you be given certain information and that we obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment, and the feasible treatment alternatives; that you have been given an opportunity to ask questions; that all your questions have been answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain.

2. CONSENT FOR DENTAL IMPLANT

I hereby authorize and direct the oral and maxillofacial surgeon whose name appears above with associates or assistants of his or her choice to perform surgery upon me (or upon any person identified above as the patient, for whom I am empowered to consent) to insert dental implant(s) in my upper and/or lower jaw and/or placement of bone graft (etc.) as needed.

3. NATURE AND PURPOSE OF THE PROCEDURE

I understand incision(s) will be made inside my mouth for the purpose of placing one or more metal structures in my jaw(s) to serve an anchor(s) for a missing tooth or teeth or to stabilize a crown (cap), denture or bridge. I acknowledge that the oral and maxillofacial surgeon whose name appears above has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap) , denture or bridge, will later be attached to this implant by a general dentist or prosthodontist and that the cost for that work is not included in the charge for this procedure. I have been informed that the implant must remain covered under the gum tissue for at least three months before it can be used and that a second surgical procedure is required to uncover the top of the implant. Finally, I understand that this is a relatively new procedure. I have received literature, anesthesia information, pre and post surgical instructions and diet information and have read and understand the information.

4. ALTERNATIVES TO A DENTAL IMPLANT

The alternatives to the use of a dental implant, including no treatment at all; construction of a new standard dental prosthesis; augmentation of the upper or lower jaw by means of a vestibuloplasty, skin and bone grafting, or with synthetic materials; and implantation of another type of device have been explained to me as have the advantages and disadvantages of each procedure and I choose to proceed with insertion of the dental implant.

5. AUTHORIZATION OF ANCILLARY TREATMENT

I also authorize and direct the oral and maxillofacial surgeon whose name appears

above with the associate or assistants of his or her choice to provide such additional services as he or they may deem reasonable and necessary, including, but not limited to , the administration of anesthetic agents; the performance of necessary laboratory, radiological (X-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion, or by other medically accepted route of administration; and the removal of bone, tissue and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices.

6. AUTHORIZATION FOR SUPPLEMENTAL TREATMENT

If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or sedation, I further authorize and direct the oral and maxillofacial surgeon whose name appears above with associates or assistants of his choice to do whatever he deems necessary and advisable under the circumstances.

7. NO GUARANTEE OF TREATMENT RESULTS

I understand that there is no way to accurately predict the healing capabilities of any particular patient following the placement of the implant and that complications do occur; and I confirm that I have been given no guarantee or assurance by the oral and maxillofacial surgeon whose name appears above, or by anyone else, as to the results that may be obtained from treatment. In the event of implant failure, there will be no refund of fees.

8. RISKS AND COMPLICATIONS ASSOCIATED WITH DENTAL IMPLANTS

I have been informed and understand that there are risks and complications from surgery, drugs, and/or anesthetics.

9. SURGICAL COMPLICATIONS

Such possibilities include but are not limited to, infection, tissue discoloration (bruising), alteration in taste and/or numbness, tingling, increased sensitivity of the lips, tongue, chin, cheek or teeth which may last for an indefinite period and may be permanent. Also possible are injury to teeth if present, loss of bone, bone fractures, nasal or sinus penetration (for implants placed in the upper jaw), chronic pain, bleeding and decreased ability to open the mouth. I have also been informed that any procedure which is outside the mouth will leave a scar on the skin, and that although a good cosmetic result is hoped for, it cannot be guaranteed.

I also understand that any of these treatment complications may necessitate medical, dental, or surgical treatment; may necessitate wiring of my teeth or jaws, and may require an additional period of recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of this implant is possible which would necessitate its removal at any time after placement. Should this happen, I understand that it may possible to insert another implant after a suitable healing period and that charge will be made for this procedure.

10. DRUG AND ANESTHETIC COMPLICATIONS

If intravenous medications are used, there may be irritation of, or damage to the

vein in which anesthetic medications are injected. I understand there are certain drugs and anesthetic risks, which could involve serious bodily injury, and are inherent of any procedure requiring their use.

11. RISKS ASSOCIATED WITH NO TREATMENT

I understand that should I **not** have this implant procedure, one or more of the following may occur: faster dissolving of the jaw bone structure, increased difficulty wearing conventional dentures, increased loss of bony support of the face, lips and cheeks, increased difficulty chewing, pain and numbness, and fracture of a very thin jawbone.

12. IMPORTANCE OF PATIENT COMPLIANCE

I agree and understand that the degree of success of any dental treatment is directly related to my cooperation and that, if I fail to cooperate as requested and instructed, I may suffer temporary or permanent injury to my dental and general health and to the dental work performed by my dentist.

I understand that the success of dental implants depends to a great extent on my maintenance and meticulous hygiene throughout my mouth and especially around the implant posts where they come through the gum tissue.

I understand that smoking, alcohol, improper dietary practices may affect gum and bone healing and will limit the success of the implant. I agree to follow home care and dietary instructions as prescribed. I will not wear my dentures for 2 weeks.

I agree to return at regular intervals as specified by the doctor for inspection of my mouth and implant cleansings by the doctor or the hygienist and to have performed such dental services as may be needed to maintain my oral health. This will involve regular and long-term follow –up care for the life of the implant.

I agree to report immediately any evidence of pain, swelling, or inflammation around my implant(s) and agree to attend the office/hospital if necessary. A reasonable fee will be charged for these visits commencing one year after placement of my implant (s).

I agree not to eat or drink anything for 6 hours prior to my surgery/anesthesia. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile, hazardous devices, or work while taking such medications and/or drugs; or until fully recovered from their effects. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four hours after my release from surgery or until further recovered from the effects of anesthetic medication and drugs that may have been given to me in the office or the hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. Failure to follow these instructions may be life threatening.

13. AUTHORIZATION OF USE OF DENTAL RECORDS

I authorize photographs, X-rays, or other viewing of my care and treatment during its progress may be used for educational purposes and research.

I hereby state that I have read and I fully understand this consent form, that I have

been given an opportunity to ask any questions I might have had, that those questions have been answered in a satisfactory manner.

Date_____

Time_____

Signature_____

Signature of relative or Representative (where required)

Witness_____