

## **CONSENT FOR DENTAL IMPLANT SURGERY**

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Patient's name

Date

You have the right to be given information about implant placement so that you can decide if you want to have the surgery. You will be asked to sign this form saying you understand what will be done, the risks that can happen and the other kinds of treatment that you could have.

1. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post surgical dental procedures.
2. I have further been informed that if no treatment is elected to replace the missing teeth, the non-treatment risks include, but are not limited to:
  - (a) Drifting, tilting and/or extrusion of remaining teeth.
  - (b) Looseness of teeth, periodontal disease (gum and bone), possibly followed by extraction(s).
  - (c) A potential jaw joint problem (TMJ/TMD) caused by a deficient, collapsed or otherwise improper bite.
3. I understand that implant success is dependent upon a number of variables including, but not limited to: individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.
4. I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia and related drugs including, but not limited to: failure of the implant (s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures. I understand that any of these complications could occur even when all dental procedures are properly performed.
5. I have been advised that smoking, alcohol or sugar consumption may effect tissue healing and may limit the success of the implant. Since there is no way to accurately predict the gum and bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my general dentist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my general dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will more than likely contribute to the failure of the implant(s).

6. I authorize my dentist to perform dental services for me, including implants and other related surgery such as bone augmentation. I understand that local anesthesia will be used such as lidocaine, carbocaine, etc. I agree to the type of anesthesia that has been discussed with me and the potential side effects. My dentist has also discussed the various kinds and types of bone augmentation material, and I have authorized him to select the material which he believes to be the best choice for my implant treatment.
7. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from those now contemplated, and if I am under any sedation, I further authorize my dentist to do whatever he deems reasonably necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure(s).

## CONSENT

To my knowledge, I have given an accurate report of my health history, I have also reported any past allergic or other reactions to drugs, food, anesthetics, blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical, dental or other health care treatment on my medical history questionnaire. I understand that certain medications like bisphosphonates can increase the risk of implant failure.

I realize and understand that the purpose of this document is evidence to the fact that I am knowingly consenting to the implant procedures recommended by my dentist.

I agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences, which result from not following my dentist's advice.

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Patient's Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date