Consent for the Surgical Placement of Dental Implants

Patient Name:_____ **Date:**_____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____1. This is my consent for my surgeon and his/her surgical team who is working with him/her to perform the following treatment/procedure/surgery:

Surgical Placement of Dental Implant(s) #_____

and any other procedure deemed necessary by my surgeon.

_____2. I have been informed of the various steps involved in the placement of dental implants and alternative treatment plans have been discussed. I understand that the particular implant I will be receiving is a metal cylinder shaped like a screw, which is surgically placed in the upper and/or lower jaw. After the implant and bone integrate, an attachment is placed to the implant so a crown, bridge or denture may be fabricated to restore function and esthetics.

_____3. I understand that placement of implants in the lower jaw depends on the amount of bone and the position of the nerve in the lower jaw and there is the possibility of a temporary or permanent numbness, or tingling of the lower lip, face, teeth, gums and/or tongue. I also understand that placement of upper implants that are close to the sinus (a hollow cavity in the upper jaw), there is a possibility of a sinus communication, which can delay healing after surgery and may require removal of the implants.

_____4. I understand that during the placement of implants there might not be adequate bone for the proper placement. At this time the surgeon might have to place bone in the surgical area and around the implant and/or abort the placement of the implant and perform a bone grafting procedure, returning at a later date for proper dental implant placement. I understand I am responsible for the additional costs that might be incurred.

_____5. I understand that implants require keratinized tissue around them for improved contact and function. I am aware that tissue grafting may be necessary to achieve the best prognosis.

_____6. I understand that regular implant maintenance is necessary to the ultimate success of my implants. My surgeon has recommended that I have implant maintenance every 4 to 6 months to help reduce complications and reduce the risk of implant failure. I also understand that I must maintain excellent oral hygiene upon the proper placement of my fixed or removable restoration after initial healing has occurred. If my oral hygiene is neglected, I understand that I cannot hold the surgeon responsible for any complications and/or failure that could occur as a result of my negligence.

_____7. It has been explained that in some instances implants fail and must be removed. Infections and foreign body reactions may also occur. I have received no guarantee of the success for my implant.

_____8. I understand that the fee for placement of the implant includes the cost of the implant, and the surgeon's fee for insertion, but does not include the cost of any necessary bone grafting and materials, restorative abutments, crowns, bridges and/or dentures. If the restorative dentist requests that the restorative abutment be placed by my surgeon an additional fee will be collected prior to placement.

_____9. My surgeon has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

a. Postoperative discomfort and swelling that may necessitate several days of at-home recuperation.
b. Bleeding that may be prolonged.
c. Injury or damage to adjacent teeth, fillings and crowns.
d. Postoperative infection that may require additional treatment.
e. Stretching of the corners of the mouth with resultant cracking and bruising.
f. Restricted mouth-opening for several days or weeks.
g. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
h. Fracture of the jaw.
i. Injury to the nerve underlying lower teeth resulting in numbness or tingling of the chin, lip, cheek, gums and /or tongue on the operated side; this may persist for several weeks, months or, in rare instances, permanently.
   Opening of the sinus cavity (a normal cavity situated above the upper teeth) requiring additional treatment.

j. Temporal mandibular joint (TMJ) disorders, clicking, popping, grinding and limited opening requiring further treatments.

_____10. 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 or hazardous devices, or return to work, while taking such medications and /or drugs; or until fully recovered from the effects of anesthetic medication and drugs that may have been given to me in the office or hospital for my care. If sedative drugs have been given to me at the time of surgery, I agree not drive myself home after surgery and will have a responsible adult drive me and accompany me home after my discharge from surgery.

_____11. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general or intravenous anesthetic. I consent to the administration of **local anes / N20 / IV anesthesia**.

_____12. I am aware that local anesthesia has potential risks and complications; swelling, bleeding, bruising and possible nerve injury, usually temporary causing prolonged numbness and discomfort in the injected areas.

_____13. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is my surgeon's opinion that the therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____14. I have had an opportunity to discuss my past medical and health history, including any serious problems and/or injuries, with my surgeon.

_____15. I am aware that smoking and consuming alcohol may effect implant and gum healing and may limit the success of dental implants. I agree to cooperate completely with the recommendation of my surgeon while I am under his/her care, realizing that failure to do so could result in a less than optimal result.

_____16. I agree that I have been given verbal and written postoperative care instructions.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English.

My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature **Date**

Doctor Signature **Date**

Rev 12/18