

IMPLANT PATIENT INFORMATION AND CONSENT FORM

Name of patient

IMPLANT AREA TO BE TREATED: _____

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.
2. My doctor has carefully examined my mouth. Alternatives to the treatment have been explained. I have tried or considered these methods, but I desire implants to replace the missing teeth.
3. I have further been informed, of the possible risk and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infections and tooth discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Other complication include inflammation of a vein injury to teeth present, sinus penetration, delayed healing, allergic reaction to drugs or medications used, among others.
4. I understand that if nothing is done any or the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, loosening of the teeth, followed by necessity of extraction. Also possible are temporomandibular joint problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done, an inability to place implants at a later date due to changes in the oral or medical conditions could exist.
5. My doctor has explained that there is no method to accurately predict the gum and bone healing capacities in each patient following the placement of implants.
6. It has been explained that in some instances implants may fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science: no guarantees or assurance as to the outcome of the results of the treatment or surgery can be made. I am aware that there is risk that the implant surgery may fail, which might require the removal of the implant with possible corrective surgery associated with the removal.
7. I understand that excessive **smoking; alcohol or blood glucose level** may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. I agree to the type of anesthesia depending on the choice made by the doctor. I agree not to operate a motor vehicle or hazardous devices for at least 24 hours or more until fully recovered from the effect of the anesthesia or drugs given for my care.
9. To my knowledge, I have given an accurate report of my physical or mental health history. I have also reported any prior allergic or unusual reaction to drug, food, insect bites, anesthetic medications, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.
10. I consent to photographic, filming, recording, rxs, of the procedures to be performed for the advance of implant dentistry, provided my identity is not revealed.
11. I request and authorize a medical/ dental service for me, including implants or other surgeries. I fully understand the contemplated procedures, surgeries, or treatment, conditions may become apparent with warrant, in the judgment of the doctor. Additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in the design, materials, or any care, if it is for my best interest. If an unforeseen condition arises in the course of the treatment which calls for the performance of the procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, with his associates or assistant of his choice, to do whatever he (they) deems near an advisable under the circumstances, including the decision not to proceed with the implant procedure.

Signature of Patient

Signature of Doctor

Witness

Date