



CONSENT FORM FOR IMPLANT SURGERY AND ANESTHESIA

1. My doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant (s) either on, in, or through the bone, and I understand that the most common types of implants available are subperiosteal (on), endosteal (in), and transosteal (through). The implant type recommended for my specific condition is endosteal. I also understand that endosteal implants (more commonly known as root form) generally have the most predictable prognosis. I promise to, and accept responsibility for failing to, return to this office for examinations and any recommended treatment, at least every 6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold my dentist harmless if my implant(s) fail as a result of my not maintaining an ongoing examination and preventive maintenance routine as stated above.
2. 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. I am further aware that there is a risk that the implant placement may fail, which might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.
3. I understand that implant success is dependent upon a number of variables including, but not limited to: operator experience, 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 these complications can occur even if all dental procedures are done properly.
5. I have been advised that smoking, alcohol or sugar consumption may effect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my 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 dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will be, at a minimum, a partial cause of implant failure, should that occur. I understand that the more I smoke, the more likely it is that my implant treatment will fail, and I understand and accept that risk.
6. I have also been advised that there is a risk that the implant may break, which may require additional procedures to repair or replace the broken implant.

7. I authorize my dentist to perform dental services for me, including implants and other related surgery such as bone augmentation. I agree to the type of anesthesia that he/she has discussed with me, listed at the end of this document, and their potential side effects. I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the effects of the anesthesia or drugs given for my care. My dentist has also discussed the various kinds and types of bone augmentation material, and I have authorized him/her to select the material which he/she believes to be the best choice for my implant treatment.
8. If an 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 I.V. sedation, I further authorize and direct my dentist, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure(s).
9. I approve any reasonable modifications in design, materials, or surgical procedures, if my dentist, in his/her professional judgment, decides it is in my best interest to do so.
10. 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, insect bites, anesthetics, pollens, dust, blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I understand that certain mental and/or emotional disorders may contraindicate implant therapy and have therefore expressly indicated I am of sound mental and emotional condition at this time.
11. I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records which identify me will be used without my express written consent.
12. I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.
13. I agree that if I do not follow my dentist's recommendations and advice for postoperative 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.
14. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION AND INFORMED CONSENT TO IMPLANT PLACEMENT AND SURGERY AND THAT ALL MY QUESTIONS, IF ANY, HAVE BEEN FULLY ANSWERED. I HAVE HAD THE OPPORTUNITY TO REVIEW THIS FORM BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY SIGNATURE WILL BE CONSIDERED CONCLUSIVE PROOF THAT I HAVE READ AND UNDERSTAND EVERYTHING CONTAINED IN THIS DOCUMENT AND I HAVE GIVEN MY CONSENT TO PROCEED WITH IMPLANT TREATMENT AND RELATED SURGERY, INCLUDING ANY ANCILLARY BONE GRAFTING PROCEDURES.

Signature: _____ Date: _____

Witness: _____ Date: _____