IMPLANT PATIENT INFORMATION AND CONSENT FORM

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. The procedure has been explained to me.

2. My doctor has carefully examined my mouth. Alternatives to this treatment and the consequences of no treatment have been explained. I have tried or considered these alternatives, but I desire an implant/implants to help secure the replaced missing tooth/teeth.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, bleeding and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

4. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.

5. It has been explained that in some instances implants 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 results of treatment or surgery can be made. Our office policy is if the implant fails from the time it is placed to the time of uncovering the implant for a two stage implant procedure, a period of approximately 3 months, then the fee will be refunded or if possible, a second attempt will be made at no additional cost to the patient.

6. I understand that excessive smoking, alcohol, or high sugar levels may effect 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.

7. I agree to the type of anesthesia chosen by the doctor, which will usually be local anesthesia.

8. To my knowledge, I have given an accurate report of my physical, health and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

9. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

10. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

_____
Signature of Doctor

_____
Witness

_____
Date

_____
Signature of Patient

If the patient is unable to sign or is a minor

(Signature of parent or legal guardian)

_____
Relationship to Patient

4-2009