INFORMED CONSENT FORM FOR IMPLANT SURGERY

1. I, _________________________________, hereby authorize and request Dr. ____________ and their assistants to perform implant surgery upon me.

2. I have been informed and I understand the purpose and nature of the implant surgery. __________ has explained to me that implant surgery is a surgical procedure whereby local anesthesia is utilized to numb the area, an incision is made into the gums and the gums are reflected back, a hole is then drilled into the bone, and an implant is then placed into that area. The gums are then surgically closed, allowed to heal, and subsequent to that a restoration is placed on top of the implant. In essence, an implant is an artificial tooth which is surgically placed into the jaw bone.

3. I have been advised by __________ that there are no guarantees to the successful placement of an implant or implants into my mouth. I understand and have been advised that the possible risks and complications involved with implant surgery include adverse reactions to anesthesia and/or drugs utilized resulting in numbness, infection, allergic reaction, rash, discoloration, and even in some cases cardiac death. I understand that, with respect to implant surgery, there are also material risks and complications including but not limited to pain, swelling, infection, and discoloration. I also understand that, with respect to implant surgery, there are risks including altered sensation, tingling, shooting pain, and numbness of the lip, tongue, chin, cheek, bone, and teeth which may occur and that this numbness may be temporary or permanent in nature. I also understand that the risks of implant surgery include damage or inflammation to veins and/or arteries, injury to surrounding teeth, bone fractures, sinus penetration, or perforation, sinus hole, delayed healing, abscesses, an infected socket, changes in my bite, trismus, which is a difficulty opening the jaw, tempormandibular joint injury and

difficulty, myofacial pain dysfunction, which is a pain condition involving the muscles of the face, the breakage of the implant necessitating its removal and/or being buried in the jaw, lacerations, scars, and damage to the tissue, and injury to teeth with fillings, crowns, and bridges.

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

5. It has been explained to me 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 assurances as to the outcome of results of treatment or surgery have been made to me.

6. I understand that there are alternative treatments include doing nothing, having a crown or bridgework set up, or dentures. Dr. ________has explained to me the risks involved with each one of these alternative treatments and I specifically reject them.

7. I understand that excessive smoking, alcohol, or sugar may effect the healing of my gums and may limit the success of the implant(s). I agree to follow my doctor's home care instructions strictly and I agree to maintain regular oral hygiene including regularly brushing my teeth, regularly using dental floss, and utilizing mouthwash. I also agree to follow up with my dentist for regular dental examinations and cleanings.

8. To my knowledge, I have given my dentist an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to foods, drugs, anesthetics, and other conditions pertaining to my health.

9. I consent to photography, filming, recording, and x-rays of the procedure and the work performed regarding the implant surgery.

10. I request and authorize __________ and their staff to perform implant surgery upon me by my signature below:

Date:_________________

Patient:

____

Witness:__________________________

Guardian of Patient:

____