CONSENT FOR TWO-STAGE OSSEOUS INTEGRATED IMPLANT SURGERY

You have the right to be given information about your proposed implant placement so you can make the decision as to whether to proceed with surgery. What you are being asked to sign is your acknowledgment that you understand the nature of the proposed treatment, the known risks associated with it, and the possible alternative treatments, and your consent to treatment.

Patient's Name_____

1. I hereby authorize Dr._____and assistants to treat the condition described as:

_____

2. The procedure offered to treat the condition has been explained to me, and I understand the nature of the procedure.

3. I understand that incisions will be made inside my mouth for the purpose of placing one or more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth/teeth replacement or to stabilize a crown (cap), bridge, or denture. I acknowledge that the doctor has explained the procedure, including the number and locations of the incisions and the type of implant to be used. I understand that the crown, bridge, or denture that will later be attached to this implant(s) will be made and attached by my general dentist, and that a separate charge will be made by that office.

4. I understand that the implant(s) must remain covered by gum tissue for at least three months before being used and that a second surgical procedure is required to uncover the top of the implant(s). No guarantee has been given about the success of the implant(s) or that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted**, the entire treatment plan must be followed and completed on schedule**. If the planned schedule is not carried out, the implant(s) may fail.

5. I have been informed of possible alternative methods of treatment (if any), including: _____ _____. I understand that other forms of treatment or no treatment at all are alternatives to the implant treatment, and the risks of those choices have been presented to me.

6. My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:

    - Post-operative discomfort and swelling that may require several days of at-home recuperation.
    - Prolonged or heavy bleeding that may require additional treatment.

- Post-operative infection that may require additional treatment.
- Stretching the corners of the mouth that may cause cracking and bruising, which may heal slowly.
- Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
- Injury to nerve branches in the lower jaw resulting in numbness, pain, or tingling of the lips, chin, cheek, gums or tongue. These symptoms may persist for several weeks, months, or in rare instances, may be permanent.
- Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally entered (sinus-lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
- Fracture of the jaw or perforation of thin bony plates.
- Use of other materials, which may have to be removed at a later date.
- Bone loss around the implants.
- Implant or prosthesis fracture or loss of the implant due to rejection by the body.
- Other:_____

7. It has been explained to me that during surgery, unforeseen conditions may be revealed which may necessitate a different procedure from that set forth in paragraph 2 above. If this occurs, my doctor will discuss the new treatment options with me.

8. I consent to the administration of the anesthesia I have chosen, which is:

   local_____

   local with nitrous oxide/oxygen analgesia_____

   local with oral premedication _____

   local with intravenous sedation_____

   general anesthesia_____

9. ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged or permanent numbness, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis), which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may occur. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage, or death.

10. 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.

11. 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.

12. I understand that smoking, alcohol, and/or sugar may effect the healing of my gums and may limit the success of the implant(s). Also, research suggests a link between selective serotonin reuptake inhibitors (SSRIs) and proton pump inhibitors (PPIs) and the increased risk of dental implant failures. Also, evidence suggests a link between a verified penicillin allergy and an increased risk of dental implant failure.

13. 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.

14. I request and authorize my dentist and their staff to perform implant surgery.

_____
Patient Signature

_____
Or Guardian of Patient Signature

_____
Witness Signature

Date: _____