CONSENT FORM FOR IMPLANT SURGERY AND ANESTHESIA

Instructions To Patient: Please take this document home and read it carefully. Note any questions you might have in the area provided in Paragraph 10. Bring this back to our office at your next appointment and the doctor will review it with you before signing on page 2.

Tooth # _________________________________

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 in the bone. 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 general 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 will 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 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.

4. 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.

Initial _______
5. 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.

6. 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).

7. 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.

8. 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 circled YES or NO to indicate whether or not I have had any past treatment or therapy of any kind or type for any mental or emotional condition.

9. 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.

10. Questions I have to ask my dentist:

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11. 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 TAKE THIS FORM HOME AND REVIEW IT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY INITIAL ON EACH PAGE ALONG WITH MY SIGNATURE BELOW 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.

Patient Signature

Date _____________________________ Witness Signature

Initial ________