

CONSENT FOR DENTAL IMPLANT SURGERY

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Patient's Name _____

Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

_____ 1. My condition has been explained to me as a **Missing Tooth or Missing Teeth** described as: _____

_____ 2. The procedure proposed to treat this condition is **Surgically Placing a Dental Implant or Implants** into my jaw bones and gums in these positions:

_____ 3. I have been informed of possible alternate methods of treatment (if any) including: _____

I understand that these other forms of treatment or no treatment at all are choices. The risks of those choices have been presented to me.

_____ 4. My doctor has explained to me that there are risks and side effects of any surgical procedure. For this procedure, the main risks include:

_____ A. Post-operative discomfort, bruising and swelling needing several days of at-home recovery.

_____ B. Bleeding that is heavy or lasts for a long time that might need more treatment.

_____ C. Injury or damage to teeth or roots of teeth that are near by the place of the implant. The injured tooth/teeth might need root canal treatment or may be lost.

_____ D. An infection after the procedure that might need more treatment or cause loss of the implant.

_____ E. Stretching of the corners of the mouth that might cause cracking and bruising and might heal slowly.

_____ F. It might be hard to open my mouth for several days. This might be from swelling and muscle soreness, or from stress on the jaw joints (TMJ). This could last several weeks or months, or it could be permanent.

_____ G. During the surgery, pieces of bone, synthetic bone, or synthetic membranes may be placed. These pieces of bone or membranes may also become infected or devitalized and require antibiotics and/or more surgical treatment.

_____ H. Allergic reactions (previously unknown) to any medications or materials used in treatment.

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- _____ I. Implants placed in lower jaw might injure the nerve that gives feeling to the face. After the surgery, there might be pain or a numb feeling in my chin, lip, cheek, gums, teeth or tongue. It is possible that I might lose my sense of taste. This might last for weeks or months. It can be permanent, but this rarely happens.
- _____ J. Opening into the sinus (a normal bony area above the upper back teeth) that might need additional treatment. If we go into the sinus on purpose to do another procedure (sinus-lift procedure with grafting), I might have several weeks of sinusitis symptoms that will need medicine and more recovery time.
- _____ K. The jaw may break and need more surgical treatment for repair.
- _____ L. Use of other bone materials, (synthetic bone-like materials or membranes) that might have to be removed at a later date.
- _____ M. Bone loss around implants and/or adjacent teeth.
- _____ N. Fracture of the Implant or the restorative parts.
- _____ O. Loss of an implant or implants.
- _____ P. Other: _____
- _____ 5. I understand that cuts (incisions) will be made inside my mouth in the gums to put one or more dental implants into my jaw bone. The implants will be the support for one or more missing tooth replacements to hold a crown, cap, bridge, partial denture, complete denture or plate. The doctor has explained the procedure, and told me how many incisions will be made, where they will be, and what kind of implants will be used. If a crown, bridge or denture is to be attached to this implant(s), this will be done by Dr. _____, and that office will bill me for that procedure.
- _____ 6. Sometimes dental implants remain covered by gum tissue during the initial healing period. If the implant is covered by gum tissue, it will have to be surgically uncovered before it can be restored by the dentist. Sometimes dental implants are left exposed through the gum tissue when placed. Gum tissue grafting or trimming may be necessary before or after restoration by the dentist.
- _____ 7. No one has promised how long the implants will last. I have been told that once the implant is put in, I need to follow through with the whole treatment plan and finish it in the time period that is set by my doctors. If this is not done, the implants may fail.
- _____ 8. If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done
- _____ 9. The anesthetic I have chosen for my surgery is:
- Local Anesthesia
 - Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
 - Oral Premedication with Local Anesthesia
 - Intravenous Sedation with Local Anesthesia
 - General Anesthesia with Local Anesthesia

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- _____ 10. **ANESTHETIC RISKS** include: pain, swelling, bruising, or infection of the vein area where the anesthesia or sedation was given. This could last a long time or make it hard for you to use your arm. This might need special care. There might be numbness that lasts a long time and allergic reactions. You might have nausea and vomiting from the IV Sedation or General Anesthesia, but this doesn't happen often. IV Sedation and General Anesthesia are serious medical procedures. They are safe, but the rare risks of heart irregularities, heart attack, stroke, brain damage or death are present.
- _____ 11. **YOUR OBLIGATIONS FOR IV SEDATION OR GENERAL ANESTHESIA IS:**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
 - B. During recovery time you should not drive, operate complicated machinery or devices, or make important decisions.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. **However**, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications directed by us, **with only a small sip of water.**
- _____ 12. I understand smoking is extremely detrimental to the success of implant surgery. I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery, including the later uncovering procedure, and to make strong efforts to give up smoking entirely.

INFORMATION FOR FEMALE PATIENTS

- _____ 13. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

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CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date