CONSENT FROM FOR IMPLANT SURGERY AND ANESHTESIA

Instructions to patient: please take this document home and read it carefully. Note any questions you might have in the area provided in paragraph 15. Bring this back to our office at your next appointment and the doctor will review it with you before signing on page 4.

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 (s) either on, in, or through the bone, and I understand that the most common types of implants available are subperiosteal (on), endosteal(in), and transosteal (through).the implant type recommended for my specific condition is circled above. I also understand that endosteal implants (most commonly known as root form) generally have the most predictableprognosis. I further understand that subperiosteal implants , if an option for me, are not as widely used as root form implants but will negate the necessity of my having the bone grafting and other surgical procedures which would be necessary for the placement of root form implants. I understand that the risk associated with the use of a subperiosteal implant if the failure and loss of the implant which could further reduce the minimal amount of existing bone which I now have, requiring more extensive bone grafting and other surgical procedures at some future time. I also understand that other dental practioners may not be familiar or experienced in the use of subperiosteal implants, including their placement, maintenance, and treating any problems which might arise involving the subperiosteal implant. I promise to, and accept responsibility for failing, to, return to this office for examination 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) fails as a result of my not maintaining an ongoing examination and preventive maintenance routine as stated above.

2. I have further been informed that if no treatment is elected to replace the missing teeth or existing dentures, the non treatment risks include, but are not limited to:

a) Maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but likely, progressive dissolution of the underlying denture-supporting jaw bone.
b) Any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time.
c) Drifting ,tilting and/or extrusion of remaining teeth.
d) Looseness of teeth, periodontal disease (gum and bone) possibly followed by extraction (s).
e) A potential joint problem (TMJ) caused by a deficient, collapsed or otherwise improper bite.

3. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no gurantees 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 may fail, which might require further corrective surgery associated with the removal .such a failure and remedial procedures could also involve additional fees being assessed.

4. I understand that the success is dependent on a number of variables including, but not limited to: operator experience, individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implants is determined in the professional judgment of my dentist.

5. 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 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.

6. I have been further 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 bone healing capabilities of each patient, I know I must follow my dentists 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 other device recommended by my dentist, is critical to the success of my treatment and my failure to do what I am suppose to do at home will be, at 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.

7. 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.

8. I authorize my dentist to perform dental services for me, including implants and other elated surgery such as bone augmentation. I agree to the type of anesthesia that he/she has discussed with me, circled below, and their potential side effects , specifically(local)(IV sedation)or (general), I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the side effects of anesthesia or drugs given for my care. May dentist has also discussed the various kinds and types of bone augmentation material,

and I have authorized him/her to select the material which he/she believes to be the best choice for my implant treatment.

9. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from the now contemplated and I am under general anesthesia or I.V. sedation, I further authorize and direct my dentis , 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).

10. I approve any reasonable modification in desig , materials, or surgical procedures, if my dentist , I his/her professional judgment, decides it is in my best interest to do so.

11. 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:bold diseases , gum or skin reactions, abnormal bleeding or any other conditions 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 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.

12. I authorize my dentist to make photos, slides, x-rays or any other visual aid of my treatment to be used for the advancement of implant dentistry in any manner my dentist deem appropriate. However, no photographs or other records which identify me will be used without my express written consent.

13. 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.

14. I agree that if I do not follow my dentist's recommendation and advice for post-operative care, my dentist may terminate the dentist patient relationship, requiring me to seek treatment from another dentist. I realize that the post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences which result from not following my dentist's advice.

15. Questions I have to ask my dentist:_____
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16. I CERTIFY THAT I HAV EREAD 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 THIS HOME AND REVIEW IT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY INITIALS ON EACH PAGE ALNONG WITH MY SIGNATURE BELOW WILL BE CONSIDERED PROOF THAT I HAVE READ AND UNDERSTAND EVRYTHING CONTAINED IN THIS DOCUMENT AND I HAVE GIVEN MY CONSENT TO PROCEED WITH IMPLANT TREATMENT AND RELATED SURGERY , INCLUDING ALL ANCILLARY BONE GRAFTING PROCEDURES.

_____ _____

Dentist signature Patient signature

_____ _____

Witness signature Witness signature

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Parent or guardian , if patient is minor

Date : _____