ARI DENTAL OFFICE

CONSENT FOR IMPLANT

Patients Name_____ Date _____

Procedure(s)_____

Dr. Aram Mohajeri has explained to me that there are certain inherent and potential risks associated with the above mentioned treatment, procedure or sedation. The risks include yet are not limited to:

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

3. I have further been informed of the possible risks and complications involved with implant surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, nerve damage, and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein or soft tissue, injury teeth present, bone fractures, bone loss, sinus penetration, delayed healing, accidental swallowing of foreign matter, allergic reactions to drugs or medication used, etc.

4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tried muscles when chewing.

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

6. It has been explained that in some instances, implants fail and must be removed. The restoration and /or implant components may fracture, require remake or repair. Compromised functional or esthetic outcome can occur as a result of implant loss or less than ideal angulation or position of the implant(s). I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

7. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the type of anesthesia, depending in the choice of the doctor, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

A R I . D E N T A L
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TORONTO, ON , M5V-3W2
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F. 4 1 6 6 4 5 3 3 4 3
S T A F F @ A R I . DENTAL

A R I . D E N T A L
451 KING STREET WEST
TORONTO, ON, M5V-1K4
T. 4 1 6 6 4 5 3 3 4 4
F. 4 1 6 6 4 5 3 3 4 3
I N F O @ A R I . DENTAL

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9. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergy or unusual reaction to drugs, food, insect bites, anesthetics, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

10. I consent to photography, filming, recording, and x-rays of the procedure to be preformed for the advancement of implant dentistry, provided my identity is not revealed.

11. I request and authorize medical/dental services for me, including implants and other surgery, I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

I understand this document and hereby give my informed consent for dental treatment.

_____ _____

Patient/Parent/ or Guardian signature Date

_____ _____

Doctor's signature Signature of witness

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