Consent for Dental Implants

Patient Name:_____ Dental Office:_____

_____**Diagnosis:** After careful examination and study of my dental condition, my dentist has advised me that my missing or unrestorable teeth may be replaced with artificial teeth supported by an implant. The alternatives to dental implants have been explained to me and may include one or more of the following options:

1. No treatment at all, leave the teeth or spaces as they are
2. Removable partial or complete denture. An appliance that replaces one or multiple teeth that must be removed and cleaned.
3. Fixed partial denture or "bridge". An appliance that is cemented permanently to surrounding teeth and can replace one or multiple teeth.

_____**Recommended Treatment:** In order to treat my condition, my dentist has recommended the use of root form dental implants. I understand that the procedure involves placing implants into the jawbone. I also understand that implant therapy, which consists of placement of the implant into the bone and restoration of the implant, can be completed in one or two phases. My dentist has informed me of approximate time frames for placement, healing, and restoration. These time frames may change due to differences in healing and circumstances when placing the implant.

_____**Surgical Phase of Implant Therapy:** I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum will be opened to expose the bone. Implants will be placed by tapping or treading them into holes that have been drilled in my jawbone. The implants will have to be snugly fitted and held tightly in place during the healing phase.

The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed for a period of three to six months. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my dentist will make the professional judgment on the management of the situation. This procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge on my jaw and thereby assist in placement, closure, and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance can then begin.

_____**Prosthetic Phase of Implant Therapy:** I understand that this phase is just as important as the surgical phase for long term success of the implant and restoration of my mouth. During this phase, an implant prosthetic device will be attached to the implant. This process may require several steps to fabricate a functional prosthesis. Depending on surgical placement, healing, and other factors the final restorative plan may need to be altered in order to provide a functional, dependable, long lasting restoration.

_____**Expected Benefits:** The purpose of dental implants is to allow me to have increased function of artificial teeth. The implants provide support, anchorage, and retention for these teeth.

_____**Principal Risks and Complications:** I understand that some people do not respond successfully to dental implants and, in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patients condition is unique, long-tern success may not occur. To help ensure the success of your implants, it is essential that you have disclosed your full medical history to your dentist.

I understand that complications may result from the implant surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing

resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to surrounding teeth, bone fractures, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible. In rare cases, it may be necessary to refer some post-operative complications to another doctor. The costs associated with any consultation or treatment with other doctors will be the patients responsibility.

Implants themselves and the prosthesis supported by implants can break and may require additional treatment. Habits and health conditions such as smoking, grinding of teeth, certain diseases, and medications can negatively effect the long term success of implants and should be discussed with your dentist.

_____**Necessary Follow-up Care and Self-Care:** I understand that it is essential for me to maintain regular visits with my dentist following placement and restoration of my implant. These appointments will include but are not limited to post operative follow up appointments, placement of implant restorations, regular checkups for cleaning and maintenance of implants and restoration. I also understand that it is important to abide by specific prescriptions and instructions given by my dentist. I further understand that maintaining the health of my implant is my responsibility and practicing good oral hygiene is essential for longterm success of my implant. Without proper home care and regular check-ups with my dentist, the tissues surrounding my implant may develop an infection, which could result in the decreased function or total loss of my implant.

_____**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences a dentist cannot predict the absolute certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

_____**Publication of Records:** I authorize photos, slides, x-rays, or any others viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the public, however, without my written permission.

Patient Consent

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits or implant therapy, the alternative treatments available, and the necessity for follow-up and self-care. I have had the opportunity to ask questions I may have in connection with the treatment and to discuss my concerns with my dentist. I affirm that I have had all my questions or concerns addressed to my satisfaction. After thorough deliberation, I hereby consent to the performance of dental implant surgery by Brent Call D.M.D, a general dentist, as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my dentist and Dr. Call

If clinical conditions prevent the placement of implants or require an alteration in the planned restorative procedures, I defer to my dentist's judgment on surgical and restorative management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure, and security if my implants.

I understand that if at anytime I develop complications, concerns, or changes occur in the way my implant feels I must contact my dentist immediately.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

Date Printed Name and Signature of Patient or Guardian

_____ _____

Date Printed Name and Signature of Witness