

CONSENT FOR TWO-STAGE OSSEOUSINTEGRATED 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 given information about your proposed implant placement so that you are able to make the decision as to whether to proceed with surgery. What you are being asked to sign is your acknowledgment that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments.

____ 1. I hereby authorize Dr. _____ and assistants to treat the condition described as _____

____ 2. The procedure offered to treat the condition has been explained to me and I understand the nature of the procedure to be: _____

____ 3. I understand that incisions will be made inside my mouth for the purpose of placing one or more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge or denture that will later be attached to this implant(s) will be made and attached by Dr. _____ and that a separate charge will be made by that office.

____ 4. I understand that the implant(s) must remain covered by gum tissue for at least three months before being used and that a second surgical procedure is required to uncover the top of the implant. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If the planned schedule is not carried out, the implant(s) may fail.

____ 5. I have been informed of possible alternative methods of treatment (if any), including:

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

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- _____ 6. My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:
- _____ A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
 - _____ B. Prolonged or heavy bleeding that may require additional treatment.
 - _____ C. Injury or damage to adjacent teeth or roots of adjacent teeth.
 - _____ D. Post-operative infection that may require additional treatment.
 - _____ E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
 - _____ F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
 - _____ G. Injury to nerve branches in the jaw or soft tissues resulting in numbness, pain or tingling of the chin, lips, cheek, gums or tongue on the operated side(s). These symptoms may persist for several weeks, months or, in rare instances, may be permanent.
 - _____ H. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally entered (sinus-lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
 - _____ I. Fracture of the jaw or perforation of thin bony plates.
 - _____ J. Use of other materials which may have to be removed at a later date.
 - _____ K. Bone loss around implants.
 - _____ L. Implant or prosthesis fracture, or loss of the implant due to rejection by the body.
 - _____ M. Other: _____
- _____ 7. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from that set forth in paragraph 2 above. I authorize my doctor and his staff to perform such additional procedures as are necessary and desirable in the exercise of professional judgment.
- _____ 8. I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in the procedure.

_____ 9. **ANESTHESIA**

The anesthesia I have chosen for my surgery is:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Oral Premedication
- Local Anesthesia with Intravenous Sedation
- General Anesthesia

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- _____ 10. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.
- _____ 11. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
- 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 recovered sufficiently to care for yourself. This may be up to 24 hours.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using 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.
- _____ 13. I understand that no guarantee of treatment results can be promised and I give my free and voluntary consent for treatment.

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness Signature

Date