



Consent Form – Placement of Dental Implants

Part 1 - Patient Doctor Information

Date: _____

Patient Name: _____

Doctors Name: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information. I need to make a good decision; it is not meant to alarm me.

Part 2 – Details of consent

Recommended treatment: Placement of dental implants in area:

Alternatives to surgery

- No treatment
- A removable conventional prosthesis
- Crown and bridge work

Possible complications

I have been informed and understand that occasionally there are complications, which include but not limited to:

- Pain and/or swelling
- Bleeding and/or bruising
- Infection
- Numbness and tingling of the lip, chin, gums, teeth, cheek and tongue which could possibly be permanent
- Limitation of jaw function
- Postoperative unfavorable reactions to drugs, such as diarrhea, nausea, vomiting and allergy
- Failure (non-integration) of the dental implant

Other procedures

During the course of the procedure, my Doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request that my Doctor performs the procedures that he thinks are better to do at this sitting rather than later on.

Anesthetic

- Local anesthesia only
- Local anesthesia with Intravenous (IV) sedation

Anesthetic risks include discomfort, nausea/vomiting, dizziness and allergic reactions. There may be inflammation at the site of an intravenous injection, which may cause prolonged discomfort and may require special care.

Guarantee

I acknowledge that no guarantee or assurance can be made as to the results that may be obtained. If the implant is to fail within the first year (non-integration), there will be no charge for the replacement of that specific implant by my Doctor (This warranty does not apply to smokers).

Part 3 – My responsibility

I agree to cooperate completely with my Doctor's recommendations while under his care. If I don't fulfill my responsibility, my results could be affected. Smoking increases the risk of post-operative complications. Therefore, my Doctor has recommended that I stop smoking two weeks prior to the scheduled surgical procedure and up to eight weeks following the completion of the procedure. I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with my Doctor.

Necessary Follow-up Care and Self-Care

Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my Doctor can evaluate and report on the outcome of the surgery upon completion of healing.

Part 4 – Miscellaneous

Fees

I know the fee that I am to be charged. As a courtesy to me, the office staff will help prepare the insurance claims should I be insured. However, the agreement of the

insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered.

Part 5 – Signature

Understanding

I have read and understand this form. I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at my Doctor’s office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize my Doctor to perform the procedure listed in the title above. I know that I am free to withdraw from treatment at any time.

Patient signature: _____ Date: _____
OR
Patient guardian: _____ Date: _____

If not the patient, what is your relationship to the patient? _____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

Doctor: _____ Date: _____