Dental Implant Placement Consent Form

Patient name: _____

My doctor has explained the nature of my condition to me: Missing tooth or teeth.

My physician has proposed the following procedure to treat or diagnose my condition: Dental implant

This means: Surgically place an implant into the supporting jawbone.

- Alternatives to this treatment have been explained.
- I further understand that no guarantees have been given by the doctor and/or manufacturers of such dental implants and that cosmetic results achieved cannot be guaranteed since it is a function of the circumstances in each case. Should an implant fail, any additional fees are at the discretion of the doctor. I understand that the fee I am to be charged has been disclosed to me and is satisfactory to me. I understand that I am responsible, with or without the aid of my dental insurance, for all payment for any procedures completed today.
- I have been informed that the purpose of this dental implant is to provide support for a crown, bridge, or denture.
- I understand that the surgical procedure is for the actual placement of the implant(s), and a second procedure is sometimes required for the exposure of the implant(s) and attachment of the abutment for the crown, bridge, or denture to attach to.
- 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 extractions. Also possible are TMJ (jaw joint problems), headaches, referred pain to the back of the neck and facial muscles, as well as sore muscles when chewing.
- The doctor will give his best professional care toward accomplishment of the desired results.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of surgery and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient.

Please feel free to ask the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other oral surgeons and implantologists.

- The substantial and frequent risks and hazards of the proposed procedure are: Restricted mouth opening; gum shrinkage; clicking or pain of the temporomandibular joints (jaw joints); tooth sensitivity to hot or cold for days or months; loose teeth; food lodging between the teeth requiring flossing for removal; and unaesthetic exposure of crown margins of teeth in the surgery area. These are usually temporary. Uncommonly, these effects may persist.
- Uncommon risks also include: Interference with speech sounds; permanent nerve injury possibly requiring nerve graft surgery.
- There will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. Should removal be required, the doctor will remove the implant at no additional cost. If I have someone else remove the implant, I am responsible for all costs and fees and will not ask the doctor to pay for it.
- Drugs; medications; anesthesia; antibiotics; pain medication; and other medications may cause adverse reactions such as redness and swelling of tissues; pain; itching; drowsiness; nausea; vomiting; dizziness; lack of coordination; miscarriage; cardiac arrest, which can be increased by the effect of alcohol or other drugs; blood clot in the legs, heart, lungs or brain; low blood pressure; heart attack; stroke; paralysis; brain damage. Sometimes after injection of a local anesthetic, patient may have prolonged numbness and/or irritation in the area of injection. When using nitrous oxide, Atarax, chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopped breathing or heartbeat. I will arrange for someone to drive me home from the office after being sedated, and to have someone watch me closely for 10 hours after the dental appointment to observe for side effects such as difficulty breathing or passing out.
- During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures deemed better to do at this sitting rather than later on.
- I understand that I must return for follow-up at least two times a year for evaluation of oral hygiene, plaque removal and a recall maintenance prophylaxis. If I fail to follow up with my periodontal maintenance visits, I understand that I accept full responsibility for failure of my dental implant and will not hold the doctor liable.
- I understand that the fee I am to be charged has been disclosed to me and is satisfactory to me. I understand that I am responsible, with or without the aid of my dental insurance, for all payment for any procedures completed today.

- I understand that the prosthetic treatments will be completed by my restorative dentist such as abutments, bridgework, crowns, and/or dentures over implants, etc. I further understand the fee for the dental implant does not include the prosthetic fee.

I hereby authorize and direct the doctor and his authorized associates and assistants to treat my condition.

I have read and understand this form.

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

Someone at the 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 Dr. _____ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above.

_____ _____

Patient or representative signature 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.

_____ _____

Dentist signature Date