Dental Implant Consent Form

Patient Name _____ **Date** _____

Chart Number _____

I have been made fully aware of the nature of implants and implant surgery, therapeutic risks, and treatment alternatives to dental implants, by initialing and signing below, I acknowledge the proposed treatment and their consequences.

Implant locations:_____

☐ **1. Acknowledge of Receipt of Information**

State law requires that you be given certain information and that we obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment and the feasible treatment alternatives. You have been given an opportunity to ask questions and that all of your questions have been answered in a satisfactory manner.

☐ **2. Consent for Dental Implant**

I hereby authorize and direct the surgeon, whose name appears below, with associates or assistants of his/her choice to perform the surgery upon me to insert dental implant(s) in my upper and/or lower jaw.

☐ **3. Nature and Purpose of the Procedure**

I understand incision(s) will be made inside my mouth for the purpose of placing one or more metal structures in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown, denture, or bridge. I acknowledge that the surgeon, whose name appears below, has explained the procedures, including the number and location of the incisions to be made, in detail. I understand that the crown, denture or bridge will later be attached to this implant by a general dentist/or agreed specialist and that the cost of that work will be my additional responsibility. I further acknowledge that a second surgical procedure is required to uncover the top of the implant and that for the first two weeks following the initial surgery, no dentures should be worn over the surgical sites without consent of the surgeon. I also understand that there will be a healing process of approximately 3 months in which I will be unable to use the implant site(s).

Finally, I have received literature, anesthesia information, pre/post surgical instructions and diet information.

☐ **4. Alternatives to a Dental Implant**

The alternatives to the use of a dental implant, including no treatment at all, construction of a new standard dental prosthesis, augmentation of the upper or lower jaw by means of vestibuloplasty, skin and bone grafting, or with synthetic materials, and implantation of another type of device have been explained to me as have the advantages and disadvantages of each procedure and I choose to proceed with insertion of the dental implant(s).

☐ **5. Authorization of Ancillary Treatment**

I also authorize and direct the surgeon, whose name appears below, with associate or assistants of his/her to provide such additional services as he/she or they may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents, the performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion, or by other medically accepted route of administration; the removal of bone, tissue and fluids for diagnostic and therapeutic purposes and the retention of disposal of same in accordance with usual practices.

☐ **6. Authorization for Supplemental Treatment**

If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or sedation, I further authorize and direct the surgeon, whose name appears below, with associates or assistants of his /her choice to do whatever he deems necessary and advisable under the circumstances.

☐ **7. No Guarantee of Treatment Results**

I understand that there is no way to accurately predict the healing capabilities of any particular patient following the placement of the implant and that complications do occur, and I confirm that I have been given no guarantee or assurance by the surgeon, whose name appears below, or by anyone else, as to the results that may be obtained from treatment. In the event of implant failure, there will be no refund of fees.

☐ **8. Surgical Complications**

Such possibilities include but are not limited to, infection, tissue discoloration (bruising), alteration in taste and/or numbness, tingling, increased sensitivity of the lips, tongue, chin, cheek, or teeth which may last for an indefinite period and may be permanent. Other possibilities are injury to teeth, if present, loss of bone, bone fractures, nasal or sinus penetration (for implants placed in the upper jaw), chronic pain, bleeding and decreased ability to open mouth. I have also been informed that any procedure that is performed outside the mouth will leave a scar on the skin and that although a good cosmetic result is hoped for, it cannot be guaranteed.

I also understand that any of these treatment complications may necessitate additional medical, dental, or surgical treatment; may necessitate wiring of my teeth or jaws, and may require an additional period of recuperation at home or even in the hospital.

Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of the implant is possible which would necessitate its removal at any time after placement. Should this happen, I understand that it may be possible to insert another implant(s) after a suitable healing period and that a charge will be made for this procedure.

☐ **9. Drug and Anesthetic Complications**

If intravenous medications are used, there may be irritation of, or damage to the vein in which anesthetic medications are injected. I understand there are certain drugs and anesthetic risks, which could involve serious bodily injury, and are inherent in any procedure requiring their use.

☐ **10. Risks Associated with No Treatment**

I understand that should I not have this implant(s) procedure, one or more of the following may occur; faster dissolving of the jaw bone structure, increased difficulty wearing conventional dentures, increased loss of bony support of the face, lips and cheeks, increased difficulty chewing, pain numbness, and fracture of a very thin jawbone.

☐ **11. Importance of Patient Compliance**

I agree and understand that the degree of success of any dental treatment is directly related to my cooperation and that, if I fail to cooperate as requested and instructed, I may suffer temporary or permanent injury to my dental and general health and to the dental work performed by my dentist.

I understand that the success of dental implants depends to a great extent on my maintenance and meticulous oral hygiene throughout my mouth and especially around the implant posts where they come through the gum tissue.

I understand that smoking, alcohol and improper dietary practices may affect bone and gum healing and may limit the success of the implant. I agree to follow home care and dietary instructions as prescribed.

I agree to return at regular intervals as specified by the doctor for inspection of my mouth and implant cleanings by the doctor or the hygienist and to perform such dental services as may be needed to maintain my oral health. This will involve regular and long term follow-up care for the life of the implant.

I agree to report immediately any evidence of pain, swelling or inflammation around my implant(s) and schedule a dental appointment if necessary. A reasonable fee will be charged for these visits commencing one year after the placement of my implant(s).

If sedated, I agree not to eat or drink anything for 6 hours prior to my surgery/anesthesia. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which may be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile, hazardous devices, or work while taking such medications and/or drugs, or until fully recovered from their effects.

I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of anesthetic medication and drugs that may have been given to me in the office or the hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. Failure to follow these instructions may be life threatening.

☐ 12. I hereby acknowledge that the surgeon is an independent contractor of the Dental Group and that this Implant Consent and billing associated with the surgeon's services are done as an accommodation for the independent contractor surgeon.

I hereby state that I have read and fully understand this consent form, that I have been given an opportunity to ask any questions I might have had and that those questions have been answered in a satisfactory manner. I also understand that I am free to withdraw my consent to treatment at any time.

By signature below I confirm that I have checked the boxes above and that by checking same I confirm that I have read the foregoing sections and understand the treatment to be undertaken, as well as the risks, benefits, and alternatives and consent to the described treatment.

Patient Full Name (Print) _____

Patient Signature _____

Oral Surgeon Signature _____