

INFORMED CONSENT FORM

PATIENT'S NAME:

I. CONSENT:

After a careful oral examination and study of my dental condition, my doctor has recommended dental implants as the method of choice to reconstruct my mouth. I have been fully informed of the nature of implants, implant surgery and implant supported artificial teeth. I hereby declare it is my wish to have the benefits of implants and consent to their surgical placement in my jaw(s).

II. IMPLANT SUCCESS:

Implant success is dependent upon a number of variables including, but not limited to operator experience, individual patient tolerance, anatomical variations, metabolic diseases, dietary and nutritional habits, smoking, alcohol consumption, clenching of teeth and inadequate oral hygiene. To my knowledge I have given complete and accurate information concerning my physical and mental health history. Implants are available in variety of designs and material (the best one or ones to be determined by the treating doctor). I agree to follow the pre and post operative instructions, medications, diet and physical care as prescribed by my doctor during the healing period.

III. NATURE OF PROCEDURE:

All surgery is performed under local anesthesia which may be supplemented by sedative drugs. The initial surgical phase consists of reflection of the gum tissue to expose the underlying bone. This is followed by precision drilling of small holes into the jawbone to the size of the implants selected. The implants are inserted and the gum tissue may or not be replaced and sutured to cover the implants. During the healing phase dentures cannot be worn for the first one or two weeks. After this healing period your dentures may need to be modified by placement of a soft plastic liner.

Following a three to twelve month period a second surgical procedure is performed to expose the dental implants. If satisfactory, plans and procedures to fabricate an implant supported appliance are begun. The program can vary considerably depending upon circumstances and the implant system used.

The prosthetic phase of treatment is as important as the surgical phase for the long term success of your dental reconstruction. The procedure should be performed by persons trained in the protocol of the restoration of the specific

implant system utilized. Additionally minor surgical corrections of gum tissue may be necessary to modify any soft tissue over growth or discrepancies.

IV. ALTERNATIVES

Alternative treatments which may be explained to me for replacement of missing teeth include: No treatment, fabrication of fixed or removable appliance, oral surgical procedure designed to provide a better base of support or foundation for a subsequent removable denture.

V. COMPLICATIONS

I have been informed and understand that occasionally there are complications with the surgery, drugs, and anesthetic. Such possibilities are pain, infection, swelling or discoloration. Numbness of the lip, tongue, chin, cheeks or teeth may occur, the exact duration of which cannot be determined and may be irreversible. Also possible are injury to teeth, bone fractures, nasal and sinus penetrations, delayed healing and allergic reactions. All these are considered potential complication of surgical procedures.

It has been explained to me that the connection between the implant and the tissue may fail and the implant must be removed. This can happen in the preliminary phase, during the initial healing of the bone to the implant or at any time in the future.

VI. NO WARRANTY OR GUARANTEE:

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed implant and restoration will be completely successful in function or appearance. Because of the uniqueness of every individual's dental condition and since the practice of dentistry is not an exact science, short or long term success cannot be promised. However, it is anticipated that the implant will be permanently retained.

VII. CONSENT TO UNKNOWN CONDITIONS:

During treatment, unknown oral conditions, which may give rise to a change in prognosis (outlook) for adjacent teeth or insufficient bone support for the implant may modify or change the original treatment plan. I therefore consent to the performance of such additional or alternative procedures as may be required in the best judgement of the treating doctor.

VIII. PROJECTED MAINTENANCE:

I have been informed that the implants, natural teeth and appliances have to be properly maintained on a daily basis. I agree to follow the specific technique and instruction taught to me by my doctor and staff. In addition, I agree to report to my doctor, or if out of town, to an approved dentist, for periodic examination and preventive treatment. This may also include adjustment of the prosthetic appliances, as needed. I will be informed when I am to be placed on maintenance status.

IX. RELEASE FOR EDUCATIONAL AN SCIENTIFIC USE:

I authorize photos, slide, x-rays or any other information indicative of my care and treatment during of after its progress to be used for educational and scientific purposes. My identity will not be revealed without my permission.

X. CERTIFICATION STATEMENT:

I certify that I have read fully and clearly understand these three pages, authorization and informed consent to surgical insertion of implants and the subsequent construction required of artificial appliances associated with the implants. All of my questions, if any, have been fully answered, clearly, and to my satisfaction.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE