OPEN & AFFORDABLE DENTAL BRACES

BP:_____/_____HR:_____BPM

CONSENT FOR DENTAL IMPLANT SURGERY

Patient Name: _____

Diagnosis: ☐ Missing Tooth ☐ Unrestorable Tooth ☐ Implant Retained Denture

Treatment: ☐ Implant Placement of Teeth #(s): _____

Alternatives: ☐ Dental Bridge

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
   - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
   - Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
   - An opening may occur from the mouth into the nasal or sinus cavities;
   - Inability to place the implant due to the local anatomy; Implant failure;
   - Discoloration and appearance changes of the gum tissue; Unsatisfactory cosmetic result;
   - Jaw fracture;
   - Bone loss around the implant(s) and/or adjacent teeth; I understand that bone grafting may be necessary

2. I have been informed of and understand that follow up visits or care, additional evaluation, treatment and/or surgery may be needed.

3. Patient's Responsibilities

   I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

   I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

   I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

   I understand and accept that the doctor cannot guarantee the results of the procedure or the length of time needed to complete my treatment. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

   If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____