Discussion and Informed Consent for Implant Placement

Patient Name: ____ Date: _________________________________

Diagnosis: ____

Treatment: ____

Dental implants are used to replace missing teeth and provide a base for artificial teeth.

Implant Location(s): ____

Patient's initials required

_______ I hereby authorize and direct Dr. ______________________ to perform the surgical placement of dental implant(s) in my upper and/or lower jaw. This procedure has a surgical phase and a healing phase followed by a prosthetic (artificial teeth) phase.

_______ I understand incision(s) will be made inside my mouth (gums) for the purpose of placing one or more metal or ceramic fixtures in my jawbone(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown, denture or bridge. I acknowledge that the doctor has explained the procedures, including the tooth number(s) and treatment location. 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 acknowledge that a second surgical procedure may be 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 prior approval of Dr. .

_______ I understand that there will be a healing process of approximately three to six months in which I will be unable to use the implant(s) for their ultimate intended purpose. I have received literature, anesthesia information, pre- and postsurgical instructions and diet information.

_______ I understand that no specific estimate can be made regarding the period for the longevity and retention of the implant(s). No guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my current condition(s). If the implant(s) have to be removed, I should be able to return to using a conventional denture or partial denture or possibly have additional implant(s) placed in the future. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant(s) may fail (become loose).

_______ I understand there will be additional maintenance for the implant(s) and that they may require repair. I am responsible for all surgical costs after the first year of treatment. I will follow the pre- and postoperative instructions that have been provided to me.

Risks, Benefits and Alternatives:

Patient's initials required

_______ a. *Risks, not limited to the following:* Though dental implant surgery has a high rate of success, as with all surgeries it carries with it the possibility of complications including, but not limited to the following:

- Swelling that worsens after 48 hours.
- Intense pain that cannot be relieved by prescription medication.
- Infection.
- Permanent loss (numbness) or alteration of nerve sensation resulting in numbness or tingling sensation in the lip, tongue (including loss of taste), cheek, chin, gums or teeth.
- Sinus infections or complications.
- Excessive or prolonged bleeding.
- Temporomandibular jaw joint (TMJ) pain or abnormal function of the jaw or jaw fracture.
- Damage to adjacent teeth, roots or fillings.
- Bone loss around the implant.
- Implant failure and loss (the bone does not grow around the implant).

I understand that if any of the above occurs I must *immediately* ____

_______ b. *Benefits, not limited to the following:* Increased chewing efficiency, improved appearance or speech, prevention of bone loss and adjacent tooth retention are the most common benefits.

_______ c. *Consequences of implants and prostheses in the mouth:* I understand that smoking, excessive alcohol consumption and chewing hard foods such as ice or hard candy may result in damage to my implants and can cause them to fail completely (become loose). Although implants can have a very high success rate, studies show that in people who smoke the success rate drops significantly.

_______ I understand that I must keep my implants and prosthesis clean by daily maintenance as well as regular checkups and cleanings at my dentist's office and have yearly X-rays to observe the bone levels around the implant(s). This is because infections around the dental implants can occur as they do around natural teeth.

_______ I understand that in addition to the risks and complications associated with implants and prosthetics, certain complications may result from the use of anesthetics (numbing agent) or sedatives. The risks, benefits and alternatives regarding anesthesia have been explained to me and I will disclose any allergies I have and/or any substances or medications I am taking because they may affect my response to the anesthetic or sedative.

Patient Criteria

Almost anyone who is missing teeth can benefit from implant treatment. Those who are experiencing chewing problems and difficulty wearing a removable dental appliance can look to a restoration anchored to an implant as a possible treatment option. Those who do not have a disease or condition that interferes with proper healing after implant surgery, i.e., uncontrolled diabetes or radiation/chemotherapy for treating cancer, and who have sufficient bone that is dense enough to secure the implants are possible candidates for an implant treatment option.

________ I understand the importance of providing my complete medical history to the dentists who are administering my implant treatment plan. I have reported any known medications, allergies or prior reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

________ I am______/I am not________currently or in the past taken bisphosphonates for the purpose of treating osteoporosis.

________ I understand that Dr. _________________________________ may decide to cancel the implant surgery once it is underway if I need supplemental bone grafts or other types of grafts to build up the ridge to allow placement, gum closure and securing of the implant(s). It may even be discovered once the surgery is underway that I am not a candidate for implant treatment.

________ I request and authorize dental services including implant surgery and other related treatment. I fully understand that during the contemplated procedure, surgery or treatment conditions may become apparent that warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in design, materials or care if my doctor determines this is in my best interest. If an unforeseen condition arises in the course of treatment that calls for the performance of procedures in addition to or different from those now contemplated or if clinical conditions turn out to be unfavorable for the use of the implant(s) or prevent the placement of implants, I further understand, authorize and direct my doctor to do whatever he/she deems necessary and advisable under the circumstances, including the decision not to proceed with the treatment.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed implant placement.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

____ ____________________

Patient or Patient's Representative Date

____ ____________________

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

____ ____________________

Dentist Signature Date