



CONSENT FOR DENTAL TREATMENT AND IMPLANT RECONSTRUCTIVE SURGERY

I hereby authorize the dentist treating me, and whomever he may designate as his assistant, to perform the necessary dental procedures including the surgical placement of a dental implant(s) under the gum or in the jaw bone(s). The dental procedures and implants will be used for the purpose of reconstructing my dentition with dentures, bridges, and/or crowns and dental fillings as previously explained to me. I authorize the dentist to provide any other procedures deemed necessary or advisable on the judgment of the dentist to complete the planned operation.

I understand the nature of my dental condition and the reason for the dental treatment and any dental implant placement operations. I have been informed of possible alternative methods of treatment, which depending on the particular case might include:

- Functioning without replacement of missing teeth
- Use of conventional removable dentures or fixed bridges.
- Ridge augmentation procedure (increasing the height of the dental ridges with bone or synthetic materials)
- Vestibuloplasty (“plastic surgery” of gum tissues to improve the denture base)

I have been informed and fully understand that there are certain inherent and potential risks involved with any dental treatment or implant surgery. These risks include, but are not limited to the following complications:

- Post-operative discomfort, swelling or bruising and jaw stiffness that may necessitate several days of home recuperation and change in diet.
- Nerve injury resulting in temporary or permanent numbness or tingling of the lip, tongue, chin, gums or cheek.
- Infection requiring medication or additional treatment.
- Opening of the sinus cavity (the normal air space situated above the upper teeth) requiring medications or additional surgical treatment.
- If intravenous medication is used, soreness at the injection site or along the vein may develop as well as some temporary discoloration of the skin.

- Injury to adjacent teeth or restorations (fillings, crowns, bridges) requiring dental treatment to repair the teeth.

I understand that despite adequate surgical, prosthetic and home care that dental treatments and dental implants can eventually fail. This requires removal of the failing tooth, teeth, or the implant and possibly replacement of the existing dental work or implant at a later date and/or adjustment of the overall dental-restorative treatment plan. I further understand that with dental implants, after the initial healing period of several months, a second minor surgical procedure is necessary to uncover the implanted fixture(s).

Following this second procedure, the temporary or permanent dental restorative work (dentures, fixed bridges crowns, etc.) must be performed by my dentist and/or prosthodontist. I am aware that in agreeing to have dental implants placed requires that I make a lifelong commitment to maintain oral health with proper home care and frequent professional visits.

I consent to the administration of anesthesia and to the use of such anesthetics and drugs as they may deem advisable. The nature and purpose of the anesthesia, possible alternative methods of anesthesia and the possibility of complications have been fully explained to me. This includes adverse drug responses, allergic reactions, aspiration, even cardiac arrest.

I consent to the taking and the publication of any photographs in the course of this procedure(s) for the purpose of advancing medical education.

I realize that it is mandatory that I give as accurate and as complete a medical and personal history as possible, as well as following any and all instructions as directed. I permit prescribed diagnostic procedures (photos, dental impressions, radiographs, etc.).

I further realize that in spite of the possible complications, my contemplated surgery is necessary and desired by me. I am aware that the practice of medicine/dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure(s).

I certify that I read and write English and have read and fully understand this consent form. I have had the opportunity to ask questions and have had the questions answered to my satisfaction.

Patient or Legal Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____