Informed Consent for the Placement of Dental Implants

Diagnosis: Missing the following tooth/teeth _____

Purpose of Implants: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth), a fixed bridge or a fixed or removable denture.

Alternative Treatment: The following reasonable alternatives to implants have been explained to me:

- Do not replace missing tooth/teeth: other teeth can shift into the empty space.
- Bridge: involves removal of tooth structure on adjacent teeth.
- Partial or complete denture: use of an ill-fitting denture may result in further damage to the bone and soft tissue in my mouth.

Type of Implant: I am aware that this procedure involves placing the titanium implant(s) into the jaw bone and that this is done by reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone and replacing the gum flap.

Surgical Procedures may involve some, or all, of the following:

- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics and sutures (stitches).
- Multiple surgeries which may involve:
    - Ensuring sufficient bone volume for implant placement by using my own bone, human donor bone or cow bone and a membrane (which may require an additional procedure to remove the membrane) followed by 3-8 months of healing.
    - Inserting the implant(s) followed by 2-6 months of healing.
    - Uncovering the top of the implant(s) (if applicable) followed by 2-4 weeks of healing
- Occasionally, it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed.
- Occasionally, the implant(s) is covered with a bone graft material and/or a membrane to further enhance healing which may necessitate an additional procedure to remove the membrane.

Risks and Complications of implant placement: I understand that the risks and complications include, but are not limited to:

- Allergic reactions to dental materials/medications,
- Bleeding,
- Swelling and/or infection,
- Pain and/or tooth sensitivity,
- Bruising,
- Perforation of upper jaw sinus or nasal cavity,
- Bone fracture,
- Slow healing,
- Temporary restriction of mouth opening,
- Increased tooth mobility,
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate…),
- Failure of the implant(s),
- Rare chance of disease spread from processed bone,
- Failure of the bone graft,
- Stress or damage to jaw joints (TMJ)

Risks and Complications of local anesthetic use: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: nerve injury, which may occur from the delivery of local anaesthesia, 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, but in some cases may be permanent.

No Warranty or Guarantee: While implants have a success rate of 98% in non-smokers and 89% in smokers, I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant(s) will be permanently retained. However, because of the uniqueness of every case, variations in patient compliance and medical health, long-term success cannot be promised.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s), may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions:
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 that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery.

I understand that uncontrolled gum disease may negatively affect the bone and soft tissue around my implant(s), and that I should proceed with any recommended gum surgery, and that I must comply with the cleaning schedule recommended by my surgeon and dentist.

I understand that heavy forces due to grinding and/or clenching can lead to the fracture of the crown(s), abutment(s), prosthetic screw(s) and/or the implant(s). I agree to have my restoring dentist fabricate a night guard to protect my investment if it is indicated in my case.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good 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 or less than optimal results.

Failure to do any of the foregoing may lead to bone loss around the implant(s), soft tissue damage and loss of the implant(s).

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to the placement of dental implant(s) as presented to me during the consultation and treatment plan presentation by the dentist.

_____ _____ _____

Signature of Responsible Party Date Patient's Name

_____

Relationship to Party (if Responsible Party is not Patient)

I confirm with my signature that I have discussed with the above-named patient the risks, potential complications, and intended benefits of the dental implants, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I place the implant(s) for him/her.

_____ _____

Signature of Dentist Date

_____ _____

Witness to Signatures Only Date