Patient Information and Consent Form for Dental Implants

1. Dr. _____ has carefully examined my mouth. Alternatives to implant therapy have been explained, and I desire implant placement to replace my missing teeth.
2. I have been informed about the implant surgery procedure.
3. Dr. _____ has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of implants, and that about 95% of implants successfully integrate into the bone. It has been explained that in a few instances implants fail and must be removed.
4. I have been informed of the possible risks and complications involved with implant surgery, drugs, and anesthesia. I have been told that all of these complications occur very infrequently. Such potential complications include pain, swelling, infection and transient discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur in a few cases. The exact duration of numbness is not predictable and infrequently may be irreversible. Also possible are: injury to adjacent teeth, bone fractures, delayed healing, and allergic reactions to drugs or medications used. Dr. _____ has explained the potential for occurrence of these specific occurrences in my case.
5. I understand that excessive smoking, alcohol, or sugar consumption may effect healing and limit the success of implants. I agree to follow my doctor's home care instructions. I agree to report to Dr. _____ for regular examination as instructed.
6. I agree to the type of anesthesia, deemed best for my needs by Dr. _____.
7. To my knowledge, I have given an accurate report of my medical history. I have also reported any prior allergic or unusual 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.
8. I consent to photography, filming, recording, and radiographs (x-rays) of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
9. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

I have read and understand the above information.

_____ _____

SIGNATURE OF DOCTOR **SIGNATURE OF PATIENT**

If the patient is unable to sign or is a minor,

_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN

_____ _____

WITNESS **DATE**