

TO: All Colorado Dental Association Members

The Dentists Professional Liability Trust Board, on 12-9-87, approved requirements for the use of dental implants. The Trust's concern in arriving at these requirements was to provide two types of protection. First, we wished to protect those members who do not work with implants by being fiducially responsible to see that this is a shared risk. Secondly, we would protect the Trust by requiring those dentists who do work with implants to meet some current and ongoing education qualifications, and thereby assure that the liability risk to the Trust would not be as great.

To allow for the use of implants (ceramic or any metallic fixture **surgically** placed in alveolar bone or basal bone excluding periodontal bone grafting materials, ridge augmentation materials and endodontic stabilizer implants), the dentist must meet the following requirements.

- A. Only Federal Drug Administration approved implants will be accepted.
- B. Sixty-four (64) hours of continuing education before coverage will begin. All hours must be completed within the past five years. These 64 hours must be documented to include:
  1. Thirty-two (32) hours of general implantology with emphasis on:
    - a. dental anatomy
    - b. pharmacology
    - c. biomaterials and biomechanics
    - d. medical evaluation criteria
    - e. wound healing and repair
    - f. periodontics
  2. Sixteen (16) hours in clinical instruction, a portion of which must include hands on experience in the system utilized.
  3. Sixteen hours (16) in the restorative phase, a portion of which must include experience in the system utilized. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.
- C. Ongoing continuing education consisting of twelve (12) hours in every twenty-four-(24) month period. May be in any of the areas listed in section B-1 above, but should include coverage of recent research or developments in one or more of these areas. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.

- D. Peer Review  
The Trust Board will have the right to evaluate the implantologist individually as to requirements being met.
- E. \$500.00 increase in premium. This increase in premium will be waived once this coverage has been carried for three (3) consecutive years with no implant claims.

To allow for the use of the **restorative** phase of implants, the dentist must meet the following requirements:

- A. Fourteen (14) hours of continuing education before coverage will begin. All hours must be completed within the past five years. These 14 hours must be documented to include the following:
  - 1. general overview of implantology
  - 2. wound healing and repair of implants
  - 3. restorative design, function, and occlusion
  - 4. restorative technique, i.e., lab support
- B. Minimum of twelve (12) hours in 24 months of continuing education i.e., study clubs, seminars, courses. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.
- C. At this time the Trust will provide coverage of the restorative phase with no additional increase in premium.

#### SUPPLEMENT

- A. Documentation concerning implants and the restorative phase must include certificates or letters of completion with signatures from course directors. These documents must verify requirements set by the Trust.
- B. A specific informed consent document is no longer required but the use of one is **strongly advised** for both phases of implant coverage.

# REPORT FORM

## THE DENTISTS PROFESSIONAL LIABILITY TRUST

### EDUCATION REQUIREMENTS FOR THE USE OF IMPLANTS

In accordance, with the requirements governing the continued use of dental implants, please submit verification of continuing education courses completed. **Documentation must include certificates of courses completed and/or letters of completion with signatures of course directors. All hours must be completed within the past five years.** Please categorize the contents of the courses as listed below. Copy, if additional report forms are needed.

#### SURGICAL PHASE EDUCATION REQUIREMENTS

1. General Implantology including anatomy, diagnostic evaluation, pharmacology, wound healing, biomaterials and periodontics.  
(32 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

1. Clinical and hands on experience including training in the system utilized. (16 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

2. Restorative phase including training in the system utilized.  
(16 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

RESTORATIVE PHASE EDUCATION REQUIREMENT

1. General Implantology including a general overview, wound healing and repair, restorative design and function, occlusion and restorative technique and lab support. (14 hrs. required)

Course \_\_\_\_\_ Date \_\_\_\_\_ Hrs \_\_\_\_\_  
Course \_\_\_\_\_ Date \_\_\_\_\_ Hrs \_\_\_\_\_  
Course \_\_\_\_\_ Date \_\_\_\_\_ Hrs \_\_\_\_\_  
Course \_\_\_\_\_ Date \_\_\_\_\_ Hrs \_\_\_\_\_

I am applying for Implant coverage for:

Surgical Phase (complete front side of this form)

Restorative Phase (see above)

Signature \_\_\_\_\_

Date \_\_\_\_\_

Approved:

Not Approved:

Reasons:

By \_\_\_\_\_

Date \_\_\_\_\_

## IMPLANT SURGERY CONSENT TO TREATMENT

1. I, \_\_\_\_\_ authorize Dr(s) \_\_\_\_\_ to provide surgical placement fo dental implants.
2. Alternatives to an implant supported and/or retained prosthesis have been explained to me. I have tried or considered these alternative treatment methods and their risks, but I desire a implant and implant prosthesis to secure and/or replace my missing teeth.
3. The implant surgical procedure has been explained to me and I understand the nature of this surgery, anesthesia, and other planned procedures. I have been advised that bone grafting and/or guided tissue regeneration may be necessary. I understand that the location of implants and need for bone grafting may very depending upon the circumstances.

Type of implant \_\_\_\_\_

Teeth #'s \_\_\_\_\_

Bone grafting \_\_\_\_\_

4. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limit to the following.
  - A. Postoperative discomfort and swelling that may require several days of at-home recuperation.
  - B. Prolong or heavy bleeding that may require additional treatment.
  - C. Injury or damage to adjacent teeth or roots of adjacent teeth.
  - D. Postoperative infection that may require additional treatment.
  - E. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
  - F. Injury to the nerve branches in the lower jaw resulting in numbness or tingling of the chin, lips, cheek, gums, or tongue on the operated side. This may persist for several; weeks, months, or in rare instances, permanently.
  - G. Opening into the sinus (a normal chamber above the upper back teeth) requiring additional treatment.
  - H. If the sinus is entered (sinus lift procedure with grafting) there will usually be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
  - I. Fracture of the jaw .
  - J. Other: \_\_\_\_\_

5. It has been explained to me that during the course of the procedure unforeseen conditions may be revealed which will necessitate additional of different procedures. I authorize my doctor and his staff to perform such procedures as necessary and desirable in the exercise of professional judgement.
6. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that not guarantees have been made to me concerning the success of my implant surgery and the associated treatment and procedures. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.
7. I have been advised that the excessive use of tobacco or alcohol may affect healing and the success of the implant. I agree to follow home care instructions and to report for recommended postoperative appointments.

8. I have been made aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, un-coordination, and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.
  
9. To my knowledge I have given an accurate report of my physical, dental, and mental health history. If I am currently in treatment for any health problems I certify that I have discussed the proposed implant procedure with my health care provider and have received his or her consent to undergo this implant procedure.
  
10. I agree that I have read, had explained to me, and understand the consent to implant surgery. I have been given the opportunity to ask questions concerning the nature of the treatment and the risks involved. I consent to the procedure knowing it has risks and limitations.

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DOCTOR

\_\_\_\_\_  
WITNESS (if available)

\_\_\_\_\_  
PARENT OR GUARDIAN (if minor)

\_\_\_\_\_  
DATED:

\_\_\_\_\_  
TIME:

**PATIENT INFORMATION AND CONSENT FORM FOR IMPLANT SURGERY**

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

1. I, \_\_\_\_\_, authorize  
Dr. (s) \_\_\_\_\_ and/or such assistants as may be  
selected by him (them) to provide implant surgery to remedy the conditions or symptoms which  
appear indicated by the diagnostic studies and/or evaluations already performed and to which have  
been explained to me: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(Explain nature of conditions, e.g., missing teeth or inability to wear previous dentures or patient's  
desire to use an implant).

2. I also authorize and direct my doctor(s), with associates or assistants of his (their)  
choice, to provide such additional services as he (they) may deem reasonable and necessary,  
including, but not limited to, the administration of anesthetic agents; the performance of necessary  
laboratory, radiological (x-ray), and other diagnostic procedures; and the administration of  
medications orally, by injection, by infusion, or by any other dentally accepted route of  
administration.

If an unforeseen condition arises in the course of treatment which calls for the  
performance of procedures in addition to or different from that now contemplated I further  
authorize and direct my doctor (s), with associates or assistants of his (their) choice, to do  
whatever he (they) deem necessary and advisable under the circumstances, including the decision  
during the surgery not to proceed with the implant procedure.

3. Alternatives to implant surgery have been explained to me, including their risks. I have  
tried or considered these alternative treatment methods and their risks, but I desire an implant to  
help secure the replacement of missing teeth. I consent to the placement of an implant under the  
gum or in the bone and I understand the implant surgery procedure.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and  
I acknowledge that no guarantees have been made to me concerning the success of my implant  
surgery and the associated treatment and procedures. I am aware that there is a risk that the  
implant surgery may fail, which might require further corrective surgery or the removal of the  
implant with possible corrective surgery associated with the removal.

**PATIENT INFORMATION AND CONSENT FORM FOR IMPLANT SURGERY**

5. The implant surgical procedure has been explained to me and I understand the nature of this surgery and anesthetic procedures to be as follows: \_\_\_\_\_

\_\_\_\_\_  
(Description in layman terms of the specific implant surgical procedure and anesthetic procedures to be performed).

6. As with any surgical procedure, there are possible complications of which you must be aware. These include, but are not limited to: limited oral function; post operative pain; bleeding; infection or abscess which may require treatment or drainage; temporary bruising of the face; allergic reactions to metal and medications; a change in sensation or numbness to the lip, chin, and/or tongue which may be of a temporary or permanent nature; an opening between the mouth and sinus which may result in an infection and/or a persistent opening requiring other surgical procedures to resolve; injury to the teeth; temporomandibular joint (jaw) problems and poor healing which may result in loss of the implant. I have also been advised that there is a risk that the implant or crown attached to the implant may break which could require additional procedures including the surgical removal of the implant. I have been advised that bone grafting and/or guided tissue regeneration may be necessary.

7. I understand if nothing is done to correct my dental condition, any of the following may occur: limited oral function; gum or bone disease; loss of bone; inflammation; infection; sensitivity; looseness and/or loss of teeth; shifting of teeth with bite changes; temporomandibular joint (jaw) problems and an inability to place implants at a later date due to changes in oral or medical conditions.

8. I have been advised that the excessive use of tobacco, alcohol or sugar may effect gum healing and may limit the success of the implant. Because there is no way to accurately predict gum and bone healing capabilities of each patient, I agree to follow my doctor's home care instructions and to report to my doctor for regular examinations, professional dental cleaning and maintenance as instructed.

9. I agree not to operate a motor vehicle or hazardous device for at least \_\_\_\_\_ hours or more until fully recovered from the effects of the anesthesia or drugs given for my care as selected by my doctor.

**PATIENT INFORMATION AND CONSENT FORM FOR IMPLANT SURGERY**

10. To my knowledge I have given an accurate report of my physical, dental and mental health history. If I am currently in treatment for any health problems I certify that I have discussed the proposed implant procedure with my health care provider and have received his or her consent to undergo this implant procedure.

11. I certify that I have read, have had explained to me, and fully understand the foregoing consent to implant surgery, drug and anesthetic procedures, and that it is my intention to have the foregoing carried out as stated. I have been advised that information concerning the longevity of the particular implant to be used may not be available. However, I have discussed this as well as the nature of the implant product to be used and I consent to the procedure knowing its risks and limitations.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (if available)

\_\_\_\_\_  
Parent or Guardian if patient is a minor

Dated: \_\_\_\_\_ Time: \_\_\_\_\_