IMPLANT SURGERY CONSENT TO TREATMENT

NOTE: To prevent excessive bleeding, avoid taking the following medication prior to surgery. If your doctor prescribed any of these, we will need to make special arrangements to prepare for your treatment.

Refrain from:
Aspirin – for at least 2 WEEKS; Baby Aspirin – for at least 1 WEEK.
Coumadin for at least 5 DAYS.
Vitamin E 800mg – for at least 2 WEEKS.
Ibuprofen – for at least 5 DAYS.
Gingko Biloba – for at least 5 DAYS.

Dr. _____ will prescribe your surgical medications as needed.

I, _____ authorize Dr. _____ to provide surgical placement of dental implants.

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 an implant and implant prosthesis to secure and/or replace my missing teeth.

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 vary depending upon the circumstances.

Type of implant _____

Teeth #'s _____

Bone grafting _____

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 limited to the following:

a.) Postoperative discomfort and swelling that may require several days of at-home recuperation.
b.) Prolonged 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 medication and additional recovery time.
i.) Fracture of the jaw.
j.) Other _____

It has been explained to me that during the course of the procedure unforeseen conditions may be revealed which will necessitate additional or different procedures. I authorize my doctor and his staff to perform such procedures as necessary and desirable in the exercise of professional judgment.

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.

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.

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 effect of the sedation.

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.

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 Signature

_____

Doctor Signature

_____

Witness Signature

_____

Date