253 DENTAL CARE

Dentistry Dedicated to Excellence

Consent for Dental Implant Surgery

I, _____, hereby authorize Dr. Mark Walker to perform the

following procedure: _____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. This information has been provided to my satisfaction. The doctor has also informed me that there are certain potential risks associated with this treatment plan or procedure. By law we provide extensive disclosure of the risks of surgery & anesthesia, many of which are extremely unlikely to occur. These include:

1. After careful oral examination and study of my dental condition, the dentist has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct the doctor and his authorized associates and assistants to treat my condition.
2. The procedure I choose to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials of human, animal, or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage, and retention for these teeth.
3. I understand this is nonetheless an elective procedure, that such procedures are performed to improve function, and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have also been advised that other alternative treatments performed for patients in my condition include, but are not limited to, a bridge, a partial denture, full denture, or other options. I understand and choose to undergo the placement of root form implant(s).
4. I understand that my gum tissue will surgically be opened to expose the bone and that implants will be placed immediately by tapping or threading them into holes that have been drilled into my jawbone. I understand that the gum tissue will then be stitched closed over or around the implant to permit healing for a period of 3-6 months. I understand that implants placed will be integrated within 3-9 months, depending on my personal healing ability.
5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure contained herin. I therefore authorize and request that the dentist and associates or assistants under direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.

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6. I have had the opportunity to discuss with the dentist the planned surgical procedure, implant placement, and my postoperative responsibilities. I understand that following the procedure during the healing process I should not smoke, drink alcohol, or use any drugs not prescribed by my doctor. I should take any antibiotics as prescribed and use pain medication as needed. If I experience an unusual amount of pain, I should contact the dentist or his associates immediately, because it may signify a problem.
7. I understand anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance and that I should not operate a motor vehicle or any other hazardous equipment for at least 24 hours after my release from surgery if Oral Conscious Sedation or IV Sedation is used. I also acknowledge that such effects are increased by the use of alcohol and that I must not use alcohol while taking these drugs.
8. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there is a risk of failure or necessity of additional treatment despite appropriate care. I have been advised that the placement of root form implants has shown long-term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. I further understand that should removal be required, the doctor will remove the implant at no additional cost. However, if I elect to have another doctor remove the implant, I am solely responsible for all costs and fees incurred in doing so and hereby release the doctor from such costs and fees imposed by another doctor.
9. The practice of dentistry and surgery is not an exact science. Although good results are expected, individual patient differences incur a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment.
10. Postoperative infection requiring additional treatment.
11. Opening of the sinus (a normal cavity situated above the upper teeth) requiring addition surgery.
12. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
13. Injury to adjacent teeth and fillings.
14. In rare circumstances, cardiac arrest or breakage of the jaw.
15. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
16. Tooth sensitivity to hot or cold for days to months, loose teeth, exposure of crown margins of teeth in the surgical area
17. Stretching of the corners of the mouth with resultant cracking and bruising.
18. Interference with speech or permanent nerve injury.
19. _____

I also understand that function and comfort will be the primary goals of this dental procedure but that success rates of each patient vary. With that in mind, no guarantees of success have been given me by Dr. Walker or any member of his staff. He has also informed me that use of tobacco, including cigarette smoking, as well as excessive alcohol consumption, can cause failure of dental implants.

I have further been advised that swelling, infection, bleeding and/or pain may be associated with any surgical procedure, including the one recommended to me by Dr. Walker, and that said conditions may occur during the life of the implants. I have also been advised that temporary or permanent numbness may occur in my tongue, lip(s), chin, gum, or jaw as a result of this procedure, as well as the possibility on sinus involvement in the upper jaw. Dr. Walker has discussed the possibility of alternative procedures for my individual needs and has offered to answer any of my questions concerning those procedures.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary. I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.
It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

I will cooperate with the dentist's recommendations for success, which includes long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits, regular follow-up appointments, and overall general health.

Having been fully informed of the above, I hereby knowingly consent to the recommended surgical procedures outlined to me by Dr. Walker, and request him to place one or more transitional implants in my jaw for the purpose of dental reconstruction and function enhancement.

I further state that I have carefully read this surgical consent form and understand the contents.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____

Patient, parent or guardian

_____ _____

Doctor Date

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