contemporary
prosthodontics

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION AND CONSENT FOR OSSEOINTEGRATED IMPLANT

We believe it is important that you be given information about your planned treatment and obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment, and the feasible treatment alternatives. Additionally, that you have been given an opportunity to ask questions and that your questions have been answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain further.

CONSENT FOR OSSEOINTEGRATED IMPLANT

I hereby authorize and direct the dental surgeon, whose name appears below, with associates or assistants of his choice, to perform surgery upon me (or upon the person identified below as the patient, for whom I am empowered to consent) to insert one or more metallic implants in my upper and/or lower jaw.

NATURE AND PURPOSE OF THE PROCEDURE

I understand incision(s) will be made inside my mouth for the purpose of placing one or more metallic implants in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a denture or bridge. I acknowledge that the dental surgeon, whose name appears below, has explained the procedure in detail, including the locationof the incisions to be made. I understand that the crown (cap), denture or bridge will later be attached to this implant by a general dentist or prosthodontist, and that the cost for that work is not included in the charge for this procedure. Although this implant should last for many years, I understand that no guarantee that it will last for any specific period of time can be or has been given. Depending upon the nature of the surgical procedure, I have been informed that the implant may be exposed with a metallic healing abutment or need to be covered under the gum tissue for up to three to six months before it can be used and that a second surgical procedure is required to uncover the top of the implant.

AUTHORIZATION FOR SUPPLEMENTAL TREATMENT

I fully understand that during and/or following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgement of my dental surgeon, additional or alternative treatment pertinent to the success of the comprehensive treatment and therefore authorize such treatment modifications or alternatives as may become necessary in the judgement of my dental surgeon. These additional services include, but are not limited to, the administration of sedative or anesthetic agents and antibiotics; the performance of necessary laboratory, radiological (x-ray) and other diagnostic procedures; the administration of medications orally or by injection, infusion or other medically accepted route of administration; and the removalof bone, soft tissue and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices.

RISKS ASSOCIATED WITH OSSEOINTEGRATED IMPLANTS

The following sequelae and risks known to be associated with this procedure and with the anesthesia have been explained to me: swelling, damage to and possible loss of other teeth, fillings, or other dental work, infection, pain, irritation of or damage to the vein into which anesthetic medications may be placed, allergic reactions to the medications used, bleeding which may be prolonged, nasal problems and infections, poor healing, loss of bone or fracture of the jaw, injury to nerves near the treatment site which may cause pain, numbness or tinglingof the lips, chin, face, mouth, teeth and tongue which is usually temporary but may be permanent, loss of or damage to the ability to taste and/or speak, stretching of the corners of the mouth with resultant cracking and/or bruising, opening of the normal sinus cavity located above the upper teeth which may lead to sinus disease requiring surgery. I also understand that treatment complications may necessitate additional medical, dental or surgical treatment and may require an additional period of recuperation at home or in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that loosening and rejection of this implant is possible which wouldnecessitate its removal. Should this happen, I understand that it may not be possible to insert another implant after a suitable healing period.

contemporary
prosthodontics

RISKS ASSOCIATED WITH SMOKING FOR DENTAL IMPLANTS AND SURGICAL PROCEDURES
I understand that current or past smoking has significant effects on the success of surgical procedures and the success and/or survival of dental implants. I understand that I have an increased risk of poorer post-operative healing and increased risk post-operative complications and/or infections. I understand that I have an increased risk of dental implant failure - both initially during osseointegration and in long-term survival. I understand that if an implant fails to integrate, my smoking is a significant contributing factor. I confirm that I have been given no guarantee by the dental surgeon, whose name appears below, or by his associates or assistants, as to the results that may be obtained from treatment.

ALTERNATIVES TO AN OSSEOINTEGRATED IMPLANT
The alternatives to an osseointegrated implant (including no treatment at all; construction of a fixed or removable dentalprosthesis; augmentation of the upper or lower jaw by means of vestibuloplasty, skin or bone grafting, or withsynthetic materials; and implantation of another type of device) have been explained to me, as have the advantages and disadvantages of each procedure and I choose to proceed with insertion of the metallic implant.

NO GUARANTEE OF TREATMENT RESULTS
I understand that surgery is not an exact science and that complications do occur; and I confirm that I have been given no guarantee by the dental surgeon, whose name appears below, or by his associates or assistants, as to the results that may be obtained from treatment.

I hereby state that I have read and that I understand this two-sided consent form, that I have been given an opportunity to ask any questions I had, that those questions have been answered in a satisfactory manner, and that I have received a copy of the signed form. I also understand that I am free to withdraw my consent to treatment at any time.

_____ _____

SIGNATURE OF PATIENT **DATE**
(or legal representative when patient cannot legally sign)

_____ _____

Signature of Witness Date

I certify that the matters set forth above were explained fully to the patient, that the patient was given an opportunity to ask questions, that all questions asked were answered in a satisfactory manner, and that all the blanks in this form were filled in prior to signature by the patient. Where this form has been signed by the patient rather than his/her representative, I certify that, in my judgement, the patient was competent to understand the matters discussed and to give his/her consent to treatment.

_____ _____

SIGNATURE OF DENTAL SURGEON **DATE**