Periodontics &
Implant DENTISTRY
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IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed of and understand the purpose and the nature of implant surgery. I also understand the process of surgically placing dental implants. The doctor has carefully examined my mouth and alternative treatments have been explained to me.

2. 2 I have been informed of the possible risks and complications involved with implant surgery. Such complications include discomfort associated with swelling, bruising and possible infection. Patients could experience numbness of the lip, tongue, chin, cheek or teeth after surgery. The exact duration cannot be determined and may be irreversible.

3. I understand that if nothing is done, any of the following could occur, bone disease or bone loss, loss of adjacent teeth, inflammation of gum tissue, infection, sensitivity and headaches that may be associated with temporomandibular joint dysfunction (TMJ).

4. The doctor has explained that there is no method to accurately predict the healing of the gum and bone in each patient following the placement of the implant(s).

5. I understand that implant dentistry is not an exact science and some implants fail. No guarantees or assurances as to the outcome can be made or given.

6. I agree to schedule and keep scheduled post-operative appointments and follow all post-operative instructions to properly care for my implant(s) after implant surgery.

7. I understand the procedure will be performed under local anesthesia. If an oral sedation is prescribed for my procedure, I agree not operate a motor vehicle and will have someone drive me to and from my appointment.

8. To my knowledge, I have accurately given my health history. I have reported all medications taken or have taken, abnormal bleeding, drug allergies along with other common or uncommon allergies and other conditions related to my overall health

9. I have consented to digital photos and x-rays of my surgical procedure for testimonials and the advancement of dental implants, provided my identity is not provided.

10. 1I authorize the medical/dental services for implant surgery. I fully understand that during and following the surgical procedure, treatment or conditions may require the professional judgment of the doctor to provide additional/alternative treatment pertinent to the success of comprehensive treatment. I also approve of any modification in design, materials or care if it is in my best interest.

_____
Doctor Signature

_____
Witness

_____
Date

_____
Patient Signature

If patient is unable to sign or is a minor-legal guardian or Parent signature is required

_____
Relationship to Patient