BONE GRAFT INFORMED CONSENT

I ______________________________, understand that when a tooth is extracted, the underlying bone tends to atrophy (shrink). Bone grafting is a method to reduce or offset this bone atrophy after extraction(s), or to supplement bone around an implant, in a large sinus cavity, or to treat pocketing around tooth.
Donor Human (Allograft) Pre-packaged cadaver bone particles-very effective and reasonable cost.

Please read carefully and ask your surgeon if you have questions regarding any of the following:

1). I have been informed, and I understand the purpose, of the bone graft procedure.
2). I understand that there may be risks and complications of any procedure including swelling, bruising, pain, bleeding, infection, altered sensation (usually numbness at the donor site), allergic reaction or other adverse reactions to medications or materials used during or after the procedure.
3). I understand that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft; and that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.
4). It has been explained to me that, in rare instances, bone grafts fail and must be removed. Lack of adequate bone growth into the bone graft replacement material could result in failure. No assurances or guarantees as to the outcome of the results of treatment or surgery can be made. I am aware that should the bone graft surgery fail, it may require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. Should the bone graft fail, I understand that alternative non- surgical prosthetic measures may have to be considered.
5). I understand that smoking or high blood sugar (diabetes) may affect gum healing and may limit the success of the bone graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
6). To my knowledge, I have given an accurate report of my health history. I have also reported any unusual reaction to drugs, anesthetics, food, insect bites, pollen or dust, any blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
7). I request and authorize medical/dental services for me, including bone grafts and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve of modifications in design, materials, or care, if it is felt this is for my best interest, including the decision not to proceed with the bone graft.
I have reviewed the above information, and have had the opportunity to have any questions/concerns addressed. Based on the information presented by my doctor(s) regarding my diagnosis, the proposed treatment, the treatment alternatives, and the associated risks and complications of such treatment, I request that you perform the planned surgical treatment.
Patient/Parent
Signature________________________Date__________Witness______________________

Doctor Signature______________________________Date____

CONSENT FORM: AUGMENTATION GRAFTING OF THE MAXILLARY SINUS

Part 1 - Patient & Doctor Information

Patient Name: ___________________________________

Doctor Name: ___________________________________

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Part 2 - Details of Consent

Condition

My doctor has explained the nature of my condition to me: Not enough bone to place a dental implant securely.

Procedure – Augmentation grafting of the maxillary sinus

My physician has proposed the following procedure to treat or diagnose my condition: Augmentation grafting of the maxillary sinus This means: Grafting of the maxillary sinus: implant a bone substitute material, freeze dried demineralized bone and/or hydroxyapatite into the floor of the sinus. The doctor will open the gum tissue, expose the bone, make a small opening in the bone, insert graft material in the maxillary sinus, and stitch the gum tissue closed. Healing usually takes 3 to 6 months, and dentures usually cannot be worn during the first few weeks. I should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least 2 weeks and not heavily blow my nose for another 2 weeks.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that for future implant placement in the posterior maxillary region I need to have placement of bone in the area of my maxillary sinus.
This bone when mature will be able to support dental implants. I hereby authorize 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 bone grafting into the maxillary sinus region. This bone graft could include materials of human, animal, plant or synthetic origin. I understand that the purpose of this procedure is to augment the volume of bone in my maxillary sinus(es) in order to provide enough support for the placement of dental implants in the future.
3. I understand that 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 to placement of dental implants include, but are not limited to, a bridge, a partial denture, full denture, or other options. I understand and choose to undergo maxillary sinus augmentation for the placement of root form implants into the maxillary sinus region in the future.
4. I understand that my gum tissue will surgically be opened to expose the bone. I understand that a small opening will be done in the bone to be able to place the graft material in the maxillary sinus. I understand that the gum tissue will then be stitched closed to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that there are inherent and potential risks in any treatment or procedure, and that such complications may require additional treatment, and that in this specific procedure the risks of surgery and anesthesia include, but are not limited to:

A. Possible sinus membrane perforation.
B. Infection requiring additional treatment or possible removal of the graft.
C. Sinusitis, even though in many instances this technique will actually improve sinusitis if present.
D. Post-operative swelling and pain.
E. Tenderness and stiffness within the chewing muscles or neck area, and difficulty opening your mouth and speaking.
F. Prolonged or heavy bleeding, formation of a hematoma (or blood clot) at the surgery site and bruising.
G. Complications of local, sedative and general anesthetic agents:
. allergic reactions
. nausea and vomiting
. inflammation, infection or bruising at the injection site

. headache and dizziness
. life-threatening reactions including heart irregularities, heart attack, brain damage or death
H. Transient though on occasion permanent numbness of the lips, tongue, tooth, chin or gum.
I. Transient though on occasion permanent increased tooth looseness or sensitivity to hot, cold, sweet or acidic foods.
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 herein. I therefore authorize and request that the doctor and his associates or assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.
6. I have had the opportunity to discuss with the doctor the planned surgical procedure, sinus elevation, and my postoperative responsibilities. I understand that following the procedure during the healing process I should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two weeks. I should take any antibiotics prescribed and use pain medication as needed. I should follow all the post operative instructions given to me verbally and/or written. If I experience an unusual amount of pain I should contact the doctor or his associates immediately, as it may signify a problem.
7. I understand that anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol, and that I must not operate a motor vehicle or any other hazardous equipment while taking these drugs. Further, I agree not to operate a motor vehicle or any other hazardous equipment for at least 48 hours after my release from surgery.
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 exists a risk of failure or necessity of additional treatment despite appropriate care.
9. I understand that after the bone in the sinus cavity has matured, that is after a period of 4 to 6 months after placement of the graft, dental implants should be placed in the area and later these implants should have artificial teeth placed in them. All this will provide adequate function and stimulus to the new bone so it does not undergo the resorption process expected when it has no chewing force stimulation.
10. I understand that the fee I am to be charged has been disclosed to me, is satisfactory to me, and includes no additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. I understand, that as a courtesy to me, the office staff will assist in the preparation and filing of necessary insurance claims should I be insured. However, I further understand that the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and in no way alleviates my responsibility to pay for services the provided. I understand that some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I understand that I am responsible for paying all co-pays and deductibles at the time services are rendered and any and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per annum. I understand that I will be fully liable for all collection costs, including court costs and attorney fees.

Alternatives

My physician has explained the following medically acceptable alternatives to be: A bridge, a partial denture, full denture, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me. If I don't have the procedure, the following may also happen: Not being able to get a dental implant.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: The graft material not incorporating enough into the jaw, requiring other prosthetic measures. These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Stiffness of facial and jaw muscles; complications involving the sinuses, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the upper cheek and eyes; sinus membrane perforation; nfection requiring additional treatment or graft removal; sinusitis, although this technique often improves sinusitis if present.

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching,

drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

Implant Database

If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes.

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

Part 3 - My Responsibility

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

Part 4 - Miscellaneous

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Miscellaneous

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

Part 5 - Signature

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. ___________________________________ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

______________________________ ______________________________

Patient or Representative Signature Date

If not the patient, what is your relationship to the patient?

____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

______________________________ ______________________________

Dentist Signature Date

CONSENT FORM: EXTRACTION OF TEETH

Part 1 - Patient & Doctor Information

Patient Name: ___________________________________

Doctor Name: ___________________________________

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Part 2 - Details of Consent

Condition

My doctor has explained the nature of my condition to me: Disease of teeth.

Procedure – Extraction of these teeth:____

My physician has proposed the following procedure to treat or diagnose my condition: Extraction of these teeth: ____This means: Removal of teeth, an irreversible process.

Extraction involves the complete removal of a tooth from the mouth. Some extractions require cutting into the gums and removing bone and/or cutting the tooth into sections prior to removal. The intended benefit of this treatment is to relieve my current symptoms and/or permit further planned treatment. The prognosis for this procedure is _________________________.
I have been informed of the following possible alternative treatments, and the costs risks & benefits of each:
_No treatment _Root Canal therapy _Filling _Crown _Gum treatment_Other_________________________.

Alternatives

My physician has explained the following medically acceptable alternatives to be:
Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care (more common from lower extraction, especially wisdom teeth, and in smokers); gum shrinkage (possibly exposing crown margins); change These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Sharp ridges or bone splinters may form later at the edge of the socket, requiring surgery to smooth or remove them. Incomplete removal of tooth fragments – to avoid injury to vital structures such as nerves or sinuses, sometimes small root tips may be left in place. Sinus involvement: the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or an opening may occur into the mouth which may require additional care. Complications of therapy may include infection, loss of fillings, injury to other teeth or soft tissues, jaw fracture, sinus exposure, or swallowing or aspiration of debris.

I understand that small root fragments may break off from the tooth being extracted, and that these fragments may be left in the jaw or may require additional surgery for removal. I understand that during surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. This may result in nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

Implant Database

If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes.

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

Part 3 - My Responsibility

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

Part 4 - Miscellaneous

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Miscellaneous

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

Part 5 - Signature

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. ___________________________________ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

_____________________________ _____________________________

Patient or Representative Signature Date

If not the patient, what is your relationship to the patient?

____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

_____________________________ _____________________________

Dentist Signature Date

CONSENT FORM: DENTAL IMPLANT(S)

Part 1 - Patient & Doctor Information

Patient Name: ___________________________________

Doctor Name: ___________________________________

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Part 2 - Details of Consent

Condition

My doctor has explained the nature of my condition to me: Missing tooth or teeth.

Procedure – Dental Implant

My physician has proposed the following procedure to treat or diagnose my condition: Dental implant This means: Surgically place an implant into the supporting jawbone.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of surgery and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other oral surgeons and implantologists.

1. After a careful oral examination and study of my dental condition, the doctor 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 that 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 done 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 jaw bone. I understand that the gum tissue will then be stitched closed over or around the implant to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that the implants placed will be integrated in 3 to 9 months time, 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 herein. I therefore authorize and request that the doctor and his associates or assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.
6. I have had the opportunity to discuss with the doctor 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 heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two weeks. I should take any antibiotics prescribed and use pain medication as needed. If I experience an unusual amount of pain I should contact the doctor or his associates immediately, as it may signify a problem.
7. I understand that anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol, and that I must not operate a motor vehicle or any other hazardous equipment while taking these drugs. Further, I agree not to operate a motor vehicle or any other hazardous equipment for at least 48 hours after my release from surgery.
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

exists 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, should 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 any such costs and fees imposed by the other doctor.

Alternatives

My physician has explained the following medically acceptable alternatives to be: A bridge, a partial denture, full denture, or other options.
Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me. If I don't have the procedure, the following may also happen: Further loss of supporting tissues or bone. A gap in the teeth.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: Restricted mouth opening; gum shrinkage; clicking or pain of the temporomandibular joints (jaw joints) tooth sensitivity to hot or cold for days up to months; loose teeth; food lodging between the teeth requiring flossing for removal; and unesthetic exposure of crown margins of teeth in the surgery area These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Interference with speech sounds; permanent nerve injury possibly requiring nerve graft surgery.
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. Should removal be required, the doctor will remove the implant at no additional cost. If I have someone else remove the implant, I am responsible for all costs and fees and will not ask the doctor to pay for it.

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

Implant Database

If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes.

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

Part 3 - My Responsibility

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

Part 4 - Miscellaneous

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Miscellaneous

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

Part 5 - Signature

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. ___________________________________ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

_____________________________ _____________________________

Patient or Representative Signature Date

If not the patient, what is your relationship to the patient?

____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

_____________________________ _____________________________

Dentist Signature Date

ImplantVision Communications LLC

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

______________________________	______________________________
Please ***print*** your name	Please ***sign*** your name
______________________________	______________________________
Legal Representative	Description of Authority

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message	☐ **Any of the Above**
☐ Text Message	☐ **None of the above** (opt out)
☐ Email	

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) ____

____
Signature of Privacy Officer

HIPAA made EASY™
©All Rights Reserved

Burris Cosmetic and Family Dentistry
199 South Street
Camden, De. 19934

Name of Patient: ____Date:_______________________

I hereby give my permission to _________________________________ and his staff to perform the following endodontic (root canal) therapy:

TREATMENT PROPOSED:____
I understand that endodontic (root canal) therapy is not an exact scientific procedure and that no guarantees can be made for a successful outcome. I acknowledge that no guarantees or assurances have been made to me concerning the results of the root canal therapy and its outcome. ______________________and his staff have explained to me alternative methods of treatment, such as extraction or no treatment at all or antibiotic treatment and I agree to the above endodontic treatment proposal.
I understand that during the endodontic procedure, certain risks are inherent in this technique. Such risks include, but are not limited to, broken instruments in the canals of the toot h, perforation of the side of the tooth requiring corrective surgical procedures ,perforation of the apex (top) of the tooth with a file instrument that may require corrective surgical procedures,
perforation into the sinus cavities on root canals performed on upper teeth requiring corrective surgical procedures, the presence of calcification or highly irregular shapes and accessory canals in the tooth which potentially limit the chance of success as well as the possibility of a numbness (usually partial – sometimes permanent) on root canals performed on lower teeth that may require subsequent corrective surgical intervention.
I have been advised of the possibility of recurring infection, in spite of the root canal therapy and of the need for additional
Treatment such as an apicoectomy (which is a surgical procedure to eliminate reoccurring infection or to remove overfill material or perforated instruments) as well as additional surgical procedures to eliminate reoccur ring infections that may not be controlled by the procedure and/or by antibiotics. Extraction of the tooth may become necessary in spite of the best endodontic techniques.
I am fully aware that a tooth treated with endodontic (root canal) therapy will become a brittle tooth and the tooth itself will become quite vulnerable to fracture in the future. This is so even if the root canal therapy is successful.
I have been advised in most cases that a full crown is recommended to be placed over the tooth to enhance its strength once the therapy is determined to have been successful. I have also been advised that oftentimes a post may be used to reinforce the strength of the tooth and the crown.
I have been given the opportunity to ask questions and have been given satisfactory answers to those questions. Knowing these risks and having my questions fully answered, I consent to the endodontic (root canal) treatment recommended. I acknowledge that I must notify ____________________ or his staff of any continuing pain, discomfort, drainage or numbness in the area that may occur after treatment sessions. I acknowledge that any medications that are prescribed for me must be taken as directed by __________________________.

Date:______________________

(Signature of Patient, Patient's Guardian or Parent's Authorized Representative)___________________________

(Witness)_____________________________________