DENTAL IMPLANT SURGERY
INFORMED CONSENT

Max Arocha, D.M.D.
1125 S University Dr
Plantation, FL 33324
(954) 432-7771

Patient's name: _____Date:_____

1. I (patient), _____, have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

2. Dr. Max Arocha (hereafter, the "Dentist"), has reviewed with me all treatment options to restore the area(s) of missing teeth, including removable dentures, crown and bridge, dental implants and NO treatment at all, as well as the associated risks, benefits and alternatives of each option. I have had a detailed explanation of what dental implants are and I understand this explanation.

3. I understand that implant treatment requires close coordination between the Dentist and myself. I understand that I'm an integral part of the team providing treatment, and that my active participation in treatment is essential. I agree to follow the instructions of the Dentist in order to assist in achieving the best outcome possible.

4. My participation will include the instructed modifications in my diet during specific periods of treatment, my taking medications prescribed for me by the Dentist; my wearing or NOT wearing prosthesis during specific periods of treatment as instructed by the Dentist, my maintaining adequate oral hygiene monitoring on an ongoing and regular basis with the Dentist and/or his or her hygienist.

5. I have further been informed of the possible risks and complications involved with implants, surgery, drugs and anesthesia including but limited to the following:

a. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible.
b. Inflammation of a vessel, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used etc.
c. Failure of implant(s) to integrate with the bone, resulting in loss of the implant(s) and possible loss of restoration.
d. Failure of the implant restoration of any of its components, resulting in the need for replacement of possible loss of restoration.
e. Late of implant failure following restoration, resulting in the need for further treatment and possible subsequent selection of alternative treatment plans

6. I understand that smoking; inadequate hygiene, alcohol, or sugar may effect gum healing and may limit the success of the implant. In addition I understand that clenching, grinding of teeth malocclusion and a variety of medical conditions can increase the risk of failure of the dental implants. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reaction to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

7. I agree to follow my dentist's home care instructions. I agree to report to my dentist for regular examinations as instructed.

8. I understand that some of the specific risks and complications of implants SURGERY may be distinct and separate from some of the risks and complications of implants RESTORATION, and that surgical risks will be or have been reviewed in detail with my dentist surgeon.

9. I understand that implant and implants restorations occasionally fail, and I understand that the Dentist, his or her assistants, hygienists and front office staff have NOT guaranteed an ideal result. In the event that my implant(s) and /or implant restoration(s) fail, I understand that there will be no refund of any fees paid to the Dentist.

10. I understand that treatment with implants will extend over a significant period of time, can be costly and that unforeseen complications may arise requesting the need for additional procedures and possibly additional professional fees.

11. I understand that photographs may be taken during my treatment to be used in teaching other professionals.

12. I acknowledge that I have had ample time to review this consent form, ask questions, and express any concern I have proceeding with treatment. All of my questions have been answered to my satisfaction. Having done so, I elect to proceed with treatment utilizing dental implants.

Patient's signature: _____ Date: _____

Witness: _____ Date: _____

Dentist's signature: _____ Date: _____