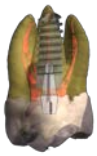

Endodontic
Microsurgical
Innovations

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Phone (610) 789-1189

CONSENT FOR SURGICAL IMPLANT TREATMENT

Patient's Name *Date*

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you may make the decision as to whether to undergo a procedure after knowing the risks and benefits.

Your planned implant surgery is: _____
Alternative treatment methods include:_____

_____1. I 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. A thorough examination has been performed, and alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure or replace the missing teeth.

It has been explained to me that certain risks and complications are associated with my surgery, which include (but are not limited to):

_____1. Bleeding, swelling, soreness, bruising, infection, stretching of the corners of the mouth, stiffness of the jaw joints (TMJ), unexpected drug reactions or allergies, fracture of the jaw or portions of bone supporting teeth, and difficulty eating for several days.

_____2. Although usually only one incision is needed to approach the selected implant site, sometimes the approach is complicated enough to require other incisions.

_____3. There may be injury to sensory nerves in the area of the surgery, resulting in pain, tingling, numbness or other sensory disturbances in the chin, lips, gums, cheek or tongue which may persist for several weeks, months or, in rare instances, may be permanent.

_____4. When operating on upper back teeth, there is a chance of entering the sinus. This may require additional care, including antibiotics, and may possibly result in an opening between mouth and sinus that may require further care. Rarely, the same complication may involve the nasal cavity.

_____5. It has been explained, and I understand, that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.

_____6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

_____*7.* *I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.*

_____*8.* *I agree to the type of anesthesia, depending on the choice of the doctor. If sedation has been prescribed / administered, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.*

ANESTHESIA

The anesthetic I have chosen for my surgery is:

☐ *Local Anesthesia*

☐ *Local Anesthesia with Oral Premedication*

☐ *Local Anesthesia with Intravenous Sedation*

_____*9.* *ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, allergic reactions and prolonged numbness at the IV site. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage and even death.*

_____*10.* *YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:*

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!

D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a small sip of water.

_____*11.* *Because of the proximity of adjacent tooth roots, there is a slight chance that these teeth may lose their vitality and require future root canal treatment or may even be lost.*

_____*12.* *It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the planned procedure. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.*

_____*13.* *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 reactions 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.*

_____*14.* *I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.*

CONSENT

I request and authorize medical/dental services for me, including implants 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 any modification in design, materials, or care, if it is felt this is for my best interest.

It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed. I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

Patient's (or Legal Guardian's) Signature *Date*

Doctor's Signature *Date*

Witness' Signature *Date*