

## IMPLANT CONSENT FORM

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. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also, possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done the bone and gum will recede over time.
5. My dentist has explained 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 may affect the gum healing and may limit the success of the implant. I agree to follow my dentist's home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. 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, anesthetics, blood disorders, abnormal bleeding or any other conditions related to my health.
9. I consent to photography and x-rays of the procedure to be performed.
10. 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 dentist, additional or alternative treatment pertinent to the success of comprehensive treatment.

Patient \_\_\_\_\_ date \_\_\_\_\_

Dentist \_\_\_\_\_ date \_\_\_\_\_