

Patient Name: _____

Date: ____/____/____

Diagnosis. After careful oral examination, a review of radiographs and study of dental condition, my dentist advised me that my missing tooth or teeth might be replaced with artificial teeth supported by an implant or implants.

I request/authorize that Dr. _____
perform the following procedure:

Recommended Treatment. I have been presented with the following options for treatment.

- No treatment
- Limited use of a new partial denture for eating and public appearance.
- Crown and bridge-work (if possible)
- Placement of titanium implant fixtures into the existing bone of the jaw, which will be used to support new restorations, fixed bridgework, or a removable denture.
- Other: _____

I have selected the option of placement titanium fixtures into the existing bone of the jaw. I am aware of the benefits and have been informed of the surgical and prosthodontic procedures, and the risks involved.

Surgical Phase of Procedure:

I understand that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will be placed, by tapping or threading them, into the holes that have been drilled into my jawbone. The implants will have a snugly fit and will be held tightly in place during the healing phase. The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of three to nine months.

I understand that dentures usually cannot be worn during the first two weeks of the healing phase. I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system, or prevent the placement of implants, my dentist will make a professional judgment of the management of the situation. The procedures also may involve supplemental bone graft or other types of grafts to build up the ridge of my jaw, and thereby to assist the placement, closure, and security of my implants. This may also include the placement of bone grafts into the maxillary sinuses to increase the height and width of bone for the appropriate insertion of implants for use as "back" teeth. After the surgery, there may be temporary pain, swelling, discoloration of the skin, and numbness or altered sensation. If sinus grafts are used, there may be nosebleeds.

Post-Operative Exam:

Post-operative examination will be required at regular intervals. (a) First visit at 7-10 days (b) Every six to eight weeks after surgery from the third month until surgical exposure of the implants. Post-operative examination will include: Visual inspection of gingival tissue, palpation of the fixture for mobility and tenderness, Periodontal tissue evaluation with respect to inflammation, Biopsy of gingival tissue, if indicated, and radiographs, if indicated.

INITIAL: _____

Post-Operative Complications:

Some problems that may occur: pain around the implant abutment fixture, infection, phobia, or change of mind by the patient. In addition, some tingling and loss of sensation in the area may occur when the implants are placed in the back of the lower jaw. In extremely rare situations, this altered or loss of sensation may be permanent.

Prognosis:

While the prognosis is favorable at this time, the results cannot be guaranteed since unforeseen changes in the bone and soft tissue may occur which may require removal of the implant fixture. If an implant fixture does not join properly with the bone, it will be necessary to remove the implant in question. No problems are usually foreseen as a result of this removal. If, on the remote possibility, the entire group of implant fixtures should fail to integrate into the bone, a new attempt can be made on a later date.

Second Surgical Procedure:

For implants requiring a second surgical procedure, the overlaying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implants. Plans and procedures to create an implant crown or appliance (By your general dentist or restorative dentist) can then begin after the gum tissue has healed.

Prosthetic Phase of Procedure:

I understand that at this point I will be referred back to my dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic device or crown will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.

Expected Benefits:

The purpose of the dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

Principal Risks and Complications:

I understand that some patients do not respond successfully to dental implants, and, in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to, post surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries, or associated muscle spasm, transient, but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum tissue upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reaction, injury to teeth, bone fractures, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and may be irreversible.

I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

INITIAL: _____

Necessary Follow-up Care and Self Care:

I understand that it is important for me to continue to see my dentist or prosthodontist. Implants, natural teeth, and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions given by my Periodontist. No warranty or Guarantee. Even though dental implants have a very high success rate, I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a Periodontist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss or devitalization of certain teeth, despite the best of care.

Publications of Records:

I authorize photos, slides, and x-rays of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

PATIENT CONSENT:

I have been fully informed of the nature of dental implant surgery, read this consent form in its entirety, understand the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self care. I have the opportunity to ask any questions or concerns I may have in connection with the treatment. I hereby consent to performance of dental implant surgery as presented to me during my consultation/treatment planning visit(s). If clinical conditions prevent the placement of dental implants, I defer to my dentist's judgment on the surgical management of that situation. I also give permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in the placement, closure, and security of my implants. I understand that the fee for my dental implant(s) and surgery does not include the fee for the restorative work. I certify that I have read and fully understand this document. I hereby give consent to Dr. Kumar & her staff to perform the necessary treatment.

Printed Name of Patient

Date: ____/____/____

Printed Name of Witness

Date: ____/____/____

Signature of Patient, Parent, or Guardian

Signature of Witness