

Informed Consent For Implant Placement

Patient Name: _____ Date of Birth: _____

Date: _____

- _____ 1. Dental implants are metal anchors placed into the jawbone, underneath the gum tissue, to support implants act as tooth root substitutes and form a strong foundation to stabilize the customized teeth.
- _____ 2. **I understand** that the placement of implants and the making of compatible prostheses are two separate treatments with separate expenses and separate risks and benefits.
- _____ 3. **I understand** that in order for the implants to be placed in my bone my gum tissue will be opened to expose the bone. Implants will be placed by pushing or threading them into holes made in the bone. The implants will have to be snugly fitted and held tightly in place during the healing phase.
- _____ 4. **I understand** that the soft tissue will be sutured closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to procedure for a period of three or nine months.
- _____ 5. **I understand** that for those types of implants that require a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be tested. If the implant appears satisfactory, an attachment will be connected to the implant by your dentist. The restorative phase to create a prosthetic appliance or crown(s) can begin.
- _____ 6. **I understand** that no specific estimate can be made regarding the period for the longevity and retention of the implant. If fixtures have to be removed, I should be able to return to using a conventional denture or partial denture or possibly have additional fixtures placed in the future. It has also been explained to me that once the implant is inserted, the entire treatment plan Must be followed and completed on schedule. If this schedule is not carried out, the implant(s) may fail.
- _____ 7. **I understand** that additional maintenance and repair may be expected for the implants. I am responsible for all surgical and x-ray costs after the first year of treatment. I agree to follow pre- and post-operative instructions.
- _____ 8. **I understand** that dentures or removable prostheses usually cannot be worn during the first one to two weeks of the healing phase.
- _____ 9. **I understand** that the practice of dentistry is not an exact science; no guarantees or assurances can be made regarding the outcome of treatment or surgery.
- _____ 10. **I understand** that excessive smoking, alcohol, or sugar may effect gum healing and my limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to to report to my doctor for **regular examinations** as instructed.
- _____ 11. **Short term effects after surgery:** There may be normal side effects that my surgeon will instruct me how to handle at home, such as: swelling, stiffness of the jaw muscles, bruising, occasional oozing of blood for 24 to 48 hours or moderate pain for 24 to 48 hours.

_____ 12. **Risks, not limited to the following:** Though dental implant surgery has a high rate of success, like all surgery it carries with it the possibility of complication not limited to the following:

- swelling that worsens after 48 hours;
- intense pain that cannot be relieved by prescription medication;
- infection;
- permanent loss or alteration of nerve sensation resulting in numbness or tingling sensation in the lip, tongue, cheek, chin, gums, or teeth;
- sinus complications;
- excessive or prolonged bleeding;
- TMJ (temporomandibular jaw joint) pain or abnormal function of the jaw, jaw fracture;
- adjacent teeth, roots, fillings, or bridgework injuries or damages;
- bone loss around the implant; and
- implant failure (the bone does not grow around the implant).

_____ 13. **I understand** that if any of the above occurs I must immediately contact Dr. Lehrian/Dr. Palo.

_____ 14. **I understand** that a medical condition can compromise the longevity of an implant.

_____ 15. **I understand** that I must keep my implants and prosthesis clean by daily maintenance as well as regular checkups and cleanings at my dentist's office.

_____ 16. **I understand** that Dr. Lehrian/Dr. Palo may decide to cancel the implant surgery once it is underway if I need supplemental bone grafts or other types of grafts to build up the ridge to allow placement, gum closure, and securing of the implant(s). It may even be discovered once the surgery is underway that I am not a candidate for implant treatment.

I have had my questions answered to my satisfaction. I consent to have Dr. Lehrian/Dr. Palo perform the oral surgery to place the necessary implants for my treatment. I authorize and direct this oral surgeon to do whatever he deems necessary and advisable under the circumstances, including not proceeding with the implant procedure once surgery is underway if I am not a candidate for implant treatment.

Patient Signature

Date

I attest that I have discussed the risks, benefits, consequences, and alternatives of implant surgery with _____ (patient's name), who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Dr. Lehrian/Dr. Palo

Date

Witness Signature

Date