



## IMPLANT INFORMATION AND CONSENT FORM

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- 1) I have been informed and understand the purpose and the nature of the dental implant surgery procedure. I understand what is necessary to accomplish the placement of the implants into the bone.
- 2) My Dentist has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but prefer dental implants.
- 3) I have further been informed of the possible risks and complications involved with surgery, drugs and anaesthesia. Such complications include pain, swelling and infection. Numbness of the lip, tongue or chin may occur. The exact duration may not be determinable and may be irreversible.
- 4) I understand that if nothing is done, any of the following may occur: loss of bone, gum tissue inflammation, infection and nerve sensitivity. Also possible are temporomandibular joint ( jaw ) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.
- 5) My Dentist has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of implants.
- 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 assurances as to the outcome of treatment or surgery can be made. However, all implants that fail to osseointegrate will be removed and then replaced at no further cost.
- 7) I understand that excessive smoking or alcohol consumption may affect gum healing and may limit the success of the implants. I agree to follow my Dentist's home care instructions, and agree to report to my Dentist for regular examinations as instructed.
- 8) I agree to Sedation or Local Anaesthetic as discussed with the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until recovered from the effects of the anaesthesia or drugs given for my care.
- 9) To my knowledge I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anaesthetics, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.
- 10) I consent to photograph, filming, recording and x - rays of the procedure to be performed for the advancement of implant dentistry, provided that my identity is not revealed.
- 11) I consent to medical/dental treatment, including implants or other surgery. I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant in the judgement 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.

Signature of Dentist: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_