AS4U0716 -IMPLANT CONSENT FORM

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DENTAL IMPLANT INFORMATION/ INFORMED CONSENT

Doctor:

TOOTH #:

Work To Be Done:
I understand I am having the following work done:

____ Dental Implant

Drugs and Medication:
I understand that antibiotics and other medications can cause allergic reactions; causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

Possible Complications:
Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Prolonged numbness, nerve damage, & bruising (hematoma) in rare instances. Possible consequences may include all those applicable to general anesthesia, including cardiovascular, pulmonary or allergic reactions up to & including death.

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GENERAL INFORMATION:
Dental Implants are designed to allow anyone missing teeth to replace the space with natural look and function. A dental implant is a metallic root formed tooth. It is placed in the bone of your jaw and allowed to heal in the bone for a period of time until the bone and implant union is strong enough to support a prosthetic tooth. At times, the union is strong enough for immediate place of the restoration. The implant is made out of titanium, a metal that is very well tolerated by the human body.
In the event that there is not enough natural bone in the site for the implant, freezed dried dematerialized bone or a substitute is used to rebuild the ridge. This helps to enlarge the ridge and make a better receptive site for the implant.

CHANGES IN TREATMENT:
I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions necessary.

I certify that I have had an opportunity to read and understand the terms and words within the above consent to this procedure.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document.

I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending doctor and me, I will give that doctor the opportunity to resolve the problem.

The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee or assurance has been made to me regarding the outcome of such dental treatment. In authorizing the abovereferenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor's professional judgment.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results. I have been told that the success of the dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction. I consent to treatment.

Signature of Patient, Parent, or Guardian: _____