Informed Consent for Dental Implants

Name: _____DOB:_____Case#_____

I hereby authorize the doctor and any associate to treat the condition described below (diagnosis)

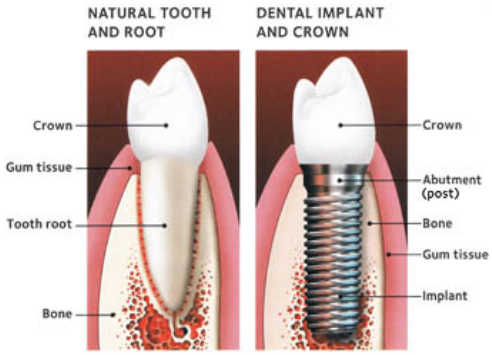
_____

_____

And to perform a dental implants on tooth/teeth number(s):

_____

_____



I understand the following treatment alternatives:

_____

_____

The prognosis for this procedure is as follows:

_____

_____

You have a right and the obligation to make decisions regarding you healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

 I request and authorize the doctor or his/her associates or assistants to perform the surgical placement of dental procedures upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

 Dental implants are metal anchors put inside the jawbone underneath the gum line. Small posts are attached to the implants and artificial teeth or dentures are fastened to the posts.

 Most patients need two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing anchors. A temporary denture may be worn for a few months while the anchors bond with the jawbone and the gums and bone heal. The second procedure will uncover the implant to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of fixed or removable bridgework or denture, are fastened to the posts. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also might be necessary to install the anchors and posts.

 Implants and the various restorations which are supported by the implants are two separate procedures. There are separate billable American Dental Associate codes representing implants and the variety of tooth restorations to be supported by the implants. Some of the possibilities are abutments extending through the gums to support a porcelain crown or a snap-on removable dental prosthesis. The fee for the surgical placement of implants **does not include the prosthesis on top of the implant.** Dr. James will discuss the variety of options with you.

 The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures.

 I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications.

 I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs including the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both know and unknown causes.

 I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following:

◦ Postoperative discomfort and swelling
◦ Bleeding
◦ Postoperative infection
◦ Injury or damage to adjacent teeth or roots of the teeth
◦ Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums or tongue
◦ Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints of the jaw-temporomandibular joint (TMJ) syndrome
◦ Fracture of the jaw
◦ Bone loss of the jaw
◦ Penetration into the sinus cavity
◦ Mechanical failure of the anchor, posts or attached teeth
◦ Failure to implant itself
◦ Allergic or adverse reaction to any medications

 Most of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

 These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization or blood transfusions. Very rarely, the potential risks and complications could result in permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment required.

 It has been explained to me that during the course of the procedure(s), unforeseen conditions may be revealed that may necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I, therefore, authorize and request that the people described above perform such procedures as are medically necessary and desirable in the exercise of their professional judgment. The authority granted under this provision shall extend to the treatment of all conditions that require treatment and are not know at the time of the original procedure is commenced.

 I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described above, and to the use of such anesthetics as may be advisable with the exception of my allergy to _____. I recognize that there are always risks to life and health associated with anesthesia and such risks have been fully explained to me.

 Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs, thus I have been advised not to operate any vehicle, automobile, or hazardous devices or to work, while taking such medications and/or drugs, or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that may have been given in the office for my care.

 It is my responsibility to contact the dentist and seek attention should any undue circumstance occur postoperatively and I shall diligently follow any and all preoperative and postoperative instructions given to me.

 I further understand that this procedure can also be performed by a specialist and request that this treatment be performed in this office by a general dentist.

OFFICE AGREEMENTS: I agree to follow the doctor's directives precisely and completely throughout my course of therapy. Following directions exactly ensures optimal care and maximizes my potential for improved health. I agree to keep regularly scheduled appointments as directed by the doctor in order to maintain continuity of care. I agree to pay for services rendered as outlined in financial agreement. I agree to conform to acceptable, peaceful behavior during my course of therapy at this office. I agree to be honest and forthright with all interactions and communications and have not misrepresented myself in patient registration information and health history matters. A breach of any of these agreements terminates the doctor/patient relationship as defined by this document.

CONSENT TO USE OF RECORDS/DUPLICATE RECORD REQUEST: I hereby give my permission for the use of records, including photographs, before, during, and after treatment for purposes of professional consultations, research, education, or publication in professional journals. Duplication of records for other health care providers *requires* that a HIPAA Authorization Form be completed and signed, and submitted with the appropriate fees for record duplication.

INFORMED CONSENT/CONSENT TO TREATMENT:
I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the doctor and have been given the opportunity to ask any questions and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered, though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me, and I accept them as satisfactory. I understand that my treatment fee covers only treatment provided by this office, and that treatment provided by other dental or medical professionals is not included in the fee for my treatment. I have been asked to make a choice about my health and treatment. I hereby consent to the treatment proposed and authorize the doctor to provide the treatment. I also authorize the doctor and/or all associates to

provide my health care information to my other health care providers as necessary. By signing this form, I am freely giving my consent to authorize the doctor and/or all associates involved in either rendering service or treatment necessary to improve the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

Good communication is essential to achieve optimal treatment result. Please call the office if you have any questions or problems regarding treatment.

_____ _____
Date Patient or Legal Guardian Signature

_____ _____
Witness Printed Name

_____
Doctor Signature

☐ Informed Refusal: I decline the treatment outlined above and accept full responsibility for the consequences of these actions.
Initials:_____