INFORMED CONSENT FOR IMPLANT SURGERY

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Patient Name (Please print) **Date**

You have the right to be given information about your proposed implant surgery so that you can make the decision as to whether or not to proceed. Please read the following paragraphs and initial in the space provided. **If you have questions with regard to the proposed procedure, please ask your doctor before signing this form.**

Dr.______________________________ has proposed the placement of implant/implants into the following position/s ____,
And to administer the anesthesia I have chosen, which is: ____ Local ____ IV Anesthesia

____ 1. I acknowledge that alternative treatments to the use of implants have been discussed with me.

____ 2. I acknowledge that the risks inherent in this procedure have been explained to me. These may include, but are not limited to, pain, infection, swelling, bruising, injury to adjacent teeth with the need for endodontic treatment (root canal) or loss, numbness to the lips, gums, side of the tongue or base of the nose (permanent or temporary), and failure of the implant or implants to take (osseointegrate) with a resultant change in the final prosthetic treatment plan.

____ 3. I acknowledge that there may be certain critical periods in the treatment where if appointments are missed or delayed, the final result may be compromised.

____ 4. I acknowledge that although a specific prosthetic restoration is intended, this may change depending on the position of the implants, the number of implants, the health of the implants, and whether or not all of the implants take (integrate).

____ 5. **I acknowledge that the cost quoted to me includes the placement of the implants in the bone and the anesthesia only. The cost of the abutment fixtures and the final restoration are additional expenses. These additional costs should be discussed with the doctor you have chosen to provide you with the final restoration.**

____ 6. I acknowledge that during treatment, conditions may develop which may require further surgery. Such procedures include, but are not limited to, mucosal/gingival grafting, treatment of infection of the soft tissue or bone, and surgical treatment of sinus infection. I realize there may be additional costs for these procedures.

____ 7. I give permission for the use of grafting or regenerative materials, either synthetic or bone/bone products, to be used to support the implant. If these materials are used, some may be temporary in nature and may have to be removed at a later date. There will be an additional charge for these materials.

____ 8. I acknowledge that although all skill and care will be used on my behalf, no guarantees as to the outcome of either the implant surgery or the prosthetics have been made.

____ 9. I understand the risks associated with the use of anesthesia, including cardiac arrest.

YOUR OBLIGATIONS IF IV ANESTHESIA IS USED: Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**

I have had the opportunity to have my questions answered and give my consent for the procedure.

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Patient/Parent or Legal Guardian's Signature Date

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Doctor's Signature Date

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Witness Signature Date