CONSENT FOR IMPLANT

I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum and in the bone. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure and replace missing teeth. I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infection, discoloration to gums, numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration maynot be determinable and may be irreversible. The possibility of inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of surrounding teeth, followed by necessity of extraction. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant. It has been explained that in some instances an implant may fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of the results of treatment or surgery can be made. I understand that excessive smoking, alcohol or sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed. I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, anesthetics, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery or treatment pertinent to the success of com[rehensive treatment. I also approve any modification in design, materials or care if it is felt by the dentist that it is in my best interest. I understand this authorization. I have been given the opportunity to ask questions and have been given satisfactory answers to my questions. I understand that this procedure can also be performed by a specialist and I prefer that it be performed in this office by a general dentist. No guarantees have been made to me.

Patient Name_____ Date_____

Patient Signature _____

Witness Signature_____

Implant Sticker _____