FAIRFAX PERIODONTAL GROUP

KHALID CHOUDHARY, DDS, MS ◊ JOAN HOWANITZ, DDS MS

DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

Consent for Dental Implants

Patient Name: _____ Date: _____

You have the right as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo the procedure(s) after knowing the risks and hazards involved. If you have any questions, please ask your doctor BEFORE signing this consent.

1. **PROCEDURES:** I understand that incisions will be made inside my mouth for the purpose of placing one or more endosteal root form structure(s) ("implants") in my jaw to serve as anchors for a missing tooth, teeth replacement or to stabilize a crown, bridge or denture. I acknowledge that the doctor(s) has explained the procedure(s), including the number location of the incisions and the type of implant to be used. I understand that the crown bridge, or denture that will later be attached to the implant(s) will be made and attached by a different restoring dentist, and that an additional fee for that crown, bridge or denture will be charged separate from the implant surgery fee.

I understand that implant(s) may remain covered by gum tissue for at least four (4) months before being able to be used and that a second surgical procedure may be required to uncover the top of the implant(s). No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant(s) is/are inserted, the ***entire treatment plan must be followed and completed on schedule****. If the planned schedule is not carried out, the implant(s) could fail. I also understand that excessive smoking, alcohol or sugar may effect gum healing and may* ***limit or prevent the success*** *of the procedure. I agree to follow my doctor's homecare instructions and to report to my doctor for regular exams.*

2. **ADDITIONAL PROCEDURES:** I understand that during the course of surgery, unforeseen conditions may be revealed which may necessitate extension of the original procedure from that planned. I authorize my doctor to perform such additional procedures as are necessary in the exercise of professional judgement.

3. **RISKS TO PREGNANT WOMEN**: I understand that it is my responsibility to advise my doctor of my pregnancy status, as the procedure(s) may involve x-rays or other radiation which an unborn child (fetus) may be exposed to.

4. **BIOPSIES:** I consent for biopsies or tissues surgically removed to be retained for study and then disposed of in accordance with appropriate medical practice.

5. **RISK OF PROCEDURE(S):** Just as there may be risks and hazards in continuing my present condition without treatment, I understand that there are also risk and hazards related to the performance of the surgical, medical, dental and/or diagnostic procedures planned for me. I realize that common to surgical, medical, dental and/or a diagnostic procedure there is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection with the planned procedure(s):
    a. Non-integration of the implant(s) or infection requiring removal of the effected implant(s).
    b. Injury or damage to adjacent teeth or roots of adjacent teeth.
    c. Post-operative infection that may require additional treatment.
    d. Stretching of the corners of the mouth that may cause cracking and bruising may heal slowly.
    e. Restricted mouth opening for several days related to swelling, muscle soreness, or stress on the jaw joints (TMJ).
    f. Injury to nerve branches in the lower jaw resulting in numbness, pain or tingling of the chin, lips, cheek, gums, or tongue on the operative side(s). These symptoms may persist for weeks, months, years or in rare instances, may be permanent. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally

entered (I.E., sinus-lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medication(s) and additional recovery time.

g. Fracture of the jaw of perforation of thin bony plates.
h. Use of other materials, which may have to be removed at a later date: _____
i. Bone loss around implants.
j. Implant or prosthesis fracture or loss of the implant due to rejection by the body.
k. Less-than-expected cosmetic and/or functional results requiring additional procedure or patient acceptance of less-than-ideal results.
l. For Zygoma implant: Damage or impairment of regional structure such as they eye/sinuses (and surrounding tissue).
m. Other:_____

6. **ANESTHESIA:** I consent to the administration of local anesthesia, with oral premedication as instructed by my doctor. I understand that risks of using anesthesia include:
    a. Discomfort
    b. Swelling
    c. Bruising
    d. Infection
    e. Prolonged numbness or dizziness
    f. Nausea
    g. Allergic reactions

7. **CONSENT:** I understand that no guarantee as to results (functional, aesthetic, or otherwise) can be or has been promised. I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____