CENTER FOR COMPREHENSIVE IMPLANT SPECIALTY AND AESTHETIC DENTISTRY

CONSENT FOR IMPLANT SURGERY/BONE GRAFTING

The implant surgery procedure has been explained to me and I understand what is necessary to accomplish the placement of the implant(s) and bone grafting under the gum or in the bone. The Dr. (s) has carefully examined me. To my knowledge, I have given an accurate report of my health history. Any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollen dusts, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions to my health are included in my health history.

I was informed of other methods which would replace missing teeth. I have tried or considered these methods and I prefer the implant(s) and/or bone grafting to help secure the replaced missing teeth. I understand that any of the following may occur: bone disease, loss of bone, loss of gum tissue, inflammation, swelling, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint problems, referred pains to the back of the neck and facial muscles, and tired muscles when chewing. I also understand that if conventional removable dentures are used, I may suffer injury to and/or loss of teeth and bone as well.

I have been informed and understand that occasionally there are complications of surgery, drugs, and/or anesthesia. Pain, swelling, infection, discoloration, and numbness of the lip, tongue, cheek, or teeth may occur - the exact duration of which may not be determinate. The numbness may be irreversible. Also possible are inflammation of a vein, injury to teeth if present, bone fractures, nasal or sinus penetration, delayed healing, and allergic reactions.

The Dr. (s) have explained to me that there is no method to accurately predict the gum and bone healing capabilities in each patient, following the placement of bone grafts and implants. I understand that smoking, alcohol, or departures from acceptable dietary practices may affect gum healing and may limit the success of the bone grafting and implant(s). Smoking has been determined to increase the failure rate of implants by as much as 10 percent.

I agree to follow home care and diet recommendations per the Dr. (s) instructions. I agree to report for check-ups as instructed. A reasonable fee will be made for these examinations after the first year of implant placement. If for any reason, at the discretion of the Dr. (s) it is deemed that the implant is not serving properly, it is agreed that the implant will be removed.

It will be replaced with conventional prosthesis or another implant, depending upon the decision of the Doctor(s).

It has been explained to me that in some patients, bone grafting and implants fail and must be removed.

With full understanding, I authorize the Dr. (s) to perform dental services for me, including bone grafting, implants and other surgery. I agree to the type of anesthesia chosen.

I agree not to operate a motor vehicle or other hazardous devices for 24 hours or until fully recovered from the effects of the anesthesia or drugs given for my care - whichever is longer. (Only applicable to patients given intravenous anesthesia or oral sedatives)

I authorize photos, slides, videos, x-rays or any other viewing of my care and treatment during its progress to be used for the advancement of dentistry. I approve any modification in designs, materials, or care if in the professional judgment of the Doctor(s) that modification is in my best interests.

I understand that there is no warranty or guarantee as to any result. I am further advised that I can get additional explanations of risks before or during the progress of my treatment merely by asking.

The procedure and its risks have been explained to me by Dr. Omid Termechi
Signed By:

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DATE PATIENT WITNESS

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