DISCUSSION AND CONSENT FOR IMPLANT PLACEMENT SURGERY

Name _____ Date of birth _____

I am being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning, I wish to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and this it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Implant Placement Surgery

Dental implants are titanium metals screws surgically placed in the jaw as a substitute for natural tooth roots. Implants permit missing teeth to be replaced through the use of crowns, fixed bridges, or dentures, which attach to the top(s) of the implant(s). It has been recommended that I have a total of _____ dental implant fixtures placed in the following tooth positions or areas of my mouth: _____. This recommendation is based on visual examination(s), on any x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration.

Implant placement surgery involves opening the gums and creating a hole in the jawbone for each dental implant. The dental implant is placed snugly in the custom hole created for it. The gums are then stitched closed over the implant. Follow-up visits are required. Following placement, implants require time to heal and attach to the surrounding bone before replacement teeth can be made to fasten on top of them I understand my expected healing time will be _____ months. During this time, I may be without replacement teeth. A second surgery is then necessary to uncover the implant and prepare it for use.

The prognosis or likelihood of success, of this procedure is _____. However, I understand that no guarantee, warrantee, or assurance has been given to me that this treatment will be successful, or for how long.

My implant(s) is (are) estimated to cost $_____ and estimated to take _____ visits to complete. After placement, it is estimated that I will be able to proceed replacing my missing teeth in _____ months.

Alternatives to Implant Placement Surgery

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to implant placement and implant-supported tooth replacement. I understand that possible alternatives to an implant-supported prosthesis may be:

- Replacement of the missing tooth or teeth by a tooth-supported fixed bridge. Natural teeth next to the toothless space are used to support a bridge, which is cemented into place and is non-removable. This procedure requires drilling the natural teeth to properly shape them to support the fixed bridge.
- Replacement of the missing tooth or teeth by a removable partial denture or full denture. Partial and full dentures are removed from the mouth for cleaning. Implants can stabilize partial or full dentures.
- No treatment. I may decide not to replace the missing tooth or teeth. If I decide upon no treatment, my teeth may shift over time, causing chewing or gum problems.

_____initials I have had an opportunity to ask questions about these alternatives.

I agree to the use of local anesthesia for this procedure. In rare situations, patients have had an allergic reaction to the anesthetic, and adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. Additionally, I agree to the use of nitrous oxide sedation ____(initial), oral sedation ____(initial), or intravenous sedation/general anesthesia ____(initial) for this procedure when such sedation or anesthesia is judged to be appropriate and necessary for this procedure.

I understand that there are certain inherent and potential risks associated with any type of surgery. The most common complications from oral surgical procedures are discomfort, pain, infection, swelling, bleeding, bruising and discoloration, all of which may last for several days. I understand that occasionally more serious complications can occur such as: temporary or permanent numbness itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues, paralysis of facial muscles. I understand that this risk is greater in the lower jaw.

Other complications may include changes in occlusion (bite) or the temporomandibular joint (TMJ), limited ability to fully open your mouth, soreness or stiffness in the jaw from holding my mouth open during treatment, possible injury to adjacent teeth and tissues, bone fractures, sinus complications, referred pain to the head or neck, nausea,

vomiting, allergic reactions and delayed healing. Although life threatening complications from this outlined surgery are extremely rare, there are inherent risks with any sedation, anesthetic and surgical procedure.

Sedatives, anesthetics and post-operative prescriptions may cause drowsiness, lack of awareness and lack of coordination. These side effects could be aggravated by the use of alcohol or other drugs. I understand and agree NOT to operate any vehicle or hazardous device or to work while taking such medications until fully recovered from their effects. This generally means a period of 12 – 24 hours if you have taken valium or halcion.

I have received post-operative instructions and I fully understand them. Furthermore, it has been explained to me and I fully understand that there is no warranty or guarantee as to any result and/or cure. I understand that I can ask for a full recital of any and all possible risks and alternatives to this procedure if I so choose.

I understand that the implant(s) may fail to properly integrate to the surrounding bone and may require removal. I understand that this may occur for unknown reason. I understand that the use of tobacco products (smoking or chewing), and certain medical conditions, such as diabetes, increase the risk that the implant(s) will fail and will require removal. I understand that poor eating habits and poor oral hygiene may negatively affect how long my implants last. I understand that the design and construction of my replacement tooth or teeth may contribute to implant failure.

I understand that additional surgical procedures may be necessary based on findings and observations revealed during surgery that are not now known.

Other foreseeable risks not stated above include _____

_____initials I have had an opportunity to ask questions about these risks and others I may have thoughts about.

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

I, A L Anderson , have received information about the proposed treatment. I have discussed my treatment with Dr. Scott L. Featherstone DDS and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the recommended treatment.

_____initials I understand this treatment can also be performed by an oral surgeon or a periodontist.

I elect to have this procedure performed by Dr. Scott L. Featherstone DDS.

I understand that if any unexpected difficulties occur during treatment, I may be referred to a dental specialist for further surgical care.

Signed: _____ Date: _____

Signed: _____ Date: _____

Scott L. Featherstone DDS

Signed: _____ Date: _____

Witness