IMPLANT PATIENT INFORMATION AND CONSENT FORM

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1. I have been informed and I understand the purpose and nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but desire an implant to help secure the replaced missing teeth. I understand that after 4-6 months of healing, I will be referred back to my dentist or to a prosthodontist for artificial teeth or crown placement.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, cheek, chin or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. 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 teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, pains to back of the neck and facial muscles, and tired muscles while chewing.
5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following placement of the implant.
6. It has been explained that in some instances, implants fail and must be repaired or removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment or surgery can be made.
7. 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.
8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
9. To my knowledge, I have given an accurate report of my physical and mental health history, including prescription drugs I am taking. I have also reported any prior allergic or unusual reactions to drugs, food or anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed. These images may be used for educational, scientific or marketing purposes.
11. 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, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of my comprehensive treatment. I also approve any modification in design, materials or care, if it is felt this is for my best interest.

Patient (or Legal Guardian) Signature	Date	Doctor Signature