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### IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. 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 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 I desire an implant to help secure the replaced missing teeth.
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, chin, cheek 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, referred pains to the back of the neck and facial muscles, and tired muscles when 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 the placement of the implant.
6. It has been explained that in some instances, implants 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 results of treatment or surgery can be made.
7. I understand that excessive smoking, alcohol, or sugar may effect 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. To my knowledge 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, insect bites, anesthetics, pollens, dust blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. 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.
10. 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 comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

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Signature of Doctor

\_\_\_\_\_  
Signature of Patient

If the patient is unable to sign or is a  
Minor (signature of parent or legal  
guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient