Link Dental | comprehensive restorative dentistry

CONSENT FORM FOR IMPLANT SURGERY AND ANESTHESIA

Instructions to Patient: Please take this document home and read it carefully. Note any questions you have in the area provided in Paragraph 15. Bring this back to our office at your next appointment, and the doctor will review it with you before signing the last page.

1. My doctor has explained the various types of implants used in dentistry, and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant(s) either on, in, or through the bone, and I understand that the most common types of implants available are subperiosteal (on), endosteal (in), and transosteal (throuqh). The implant type recommended for my specific condition is *circled above.* I also understand that endosteal implants (more commonly known as *root-form)* generally have the most predictable prognosis. I further understand that subperiosteal implants, if an option for me, are not as widely used as root-form implants but will negate the necessity of bone grafting and other surgical procedures that would be necessary for the placement of root-form implants. I understand that the risk associated with the use of a subperiosteal implant is failure and loss of the implant, which could further reduce the minimal amount of existing bone that I now have, requiring more extensive bone grafting and other surgical procedures at some future time. I also understand that other dental practitioners may not be familiar or experienced in the use of subperiosteal implants, including their placement, maintenance, and treating any problems that might arise involving the subperiosteal implant. I agree to, and accept responsibility for failing to, return to this office for examinations and any recommended treatment at least every 6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold my dentist harmless if my implant(s) fail as a result of my failure to maintain an ongoing examination and preventive maintenance routine as stated above.
2. I have further been informed that if no treatment is elected to replace the missing teeth or existing dentures, the nontreatment risks include, but are not limited to:
   (a.) Maintenance of the existing full or partial denture(s) with relines or remakes every 3 to 5 years or as otherwise may be necessary because of the likely gradual and progressive dissolution of the underlying denture-supporting jawbone.
   (b.) Persistence or worsening over time of any present discomfort or chewing inefficiency with the existing partial or full denture
   (c.) Drifting, tilting, and/or extrusion of remaining teeth
   (d.) Looseness of teeth and periodontal disease (gum and bone), possibly followed by extractions.
   (e.) A potential jaw joint problem (TMJ) caused by a deficient, collapsed, or otherwise improper.

_____
Initial

3. I am aware that the practice of dentistry and dental surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the postsurgical dental procedures. I am further aware that there is a risk that the implant placement may fail, which might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.
4. I understand that implant success is dependent upon a number of variables, including but not limited to: operator experience, individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.
5. I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia, and related drugs, including but not limited to: failure of the implant(s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing, or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures. I understand that these complications can occur even if all dental procedures are done properly.
6. I have been advised that smoking and alcohol or sugar consumption may affect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my dentist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my dentist, is critical to the success of my treatment, and my failure to do what I have been instructed to do at home will be, at minimum, a partial cause of implant failure, should that occur, I understand that the more I smoke, the more likely it is that my implant treatment will fail, and I understand and accept that risk.
7. I have also been advised that there is a risk that the implant may break, which may require additional procedures to repair or replace the broken implant.
8. I authorize my dentist to perform dental services for me, including implants and other related surgery .such as bone augmentation. I agree to the type of anesthesia-local, IV sedation, or general-that he or she has discussed with me *(circled above)* and have been informed of any potential side effects. I agree not to operate a motor vehicle or other device that may be hazardous to my or others' safety for at least 24 hours and until fully recovered from the effects of the anesthesia or drugs given for my care. My dentist has also discussed the various types of bone augmentation material, and I have authorized him or her to select the material that he or she believes to be the best choice for my implant treatment.
9. If an unforeseen condition arises in the course of treatment that calls for the performance of procedures in addition to or different from those now contemplated and I am under general anesthesia or IV sedation, I further authorize and direct my dentist and his or her associates or assistants to do whatever they deem necessary and advisable under the Circumstances, including the decision not to proceed with the implant procedure(s).
10. I approve any reasonable modifications in design, materials, or surgical procedures if my dentist, in his or her professional judgment, decides it is in my best interest to do so.

_____

Initial

11. To my knowledge, I have given an accurate report of my health history. I have also reported on my medical history questionnaire any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, or dust; blood diseases; gum or skin reactions; abnormal bleeding; or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental, or other health care treatment. I understand that certain mental and/or emotional disorders may contraindicate implant therapy and have therefore expressly *circled* either YES or NO to indicate whether or not I have had any past treatment or therapy of any kind for a mental or emotional condition.
12. I authorize my dentist to make photographs, slides, x-rays, or any other visual records of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or. other records that identify me will be used without my express written consent.
13. I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.
14. I agree that if I do not follow my dentist's recommendations and advice for postoperative care, my, dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that postoperative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences that result from not following my dentist's advice.
15. Questions for Dr. Link _____
    _____
    _____
    _____
16. I certify that I have read and fully understand the above authorization and informed consent to implant placement and surgery and that all my questions, if any, have been fully answered. I have had the opportunity to take this form home and review it before signing it. I understand and agree that my initial on each page, along with my signature below, will be considered conclusive proof that I have read and understand everything contained in this document and I have given my consent to proceed with implant treatment related surgery, including any ancillary bone grafting procedures.

_____ _____

Signature of dentist Signature of patient

_____ _____

Signature of witness Signature of witness

_____

Signature of parent or guardian (if patient is a minor)

_____

Date