

Informed Consent for Dental Implant Placement Surgery

Patient Name: _____ Date: _____

An Atlanta Dental Group PC dentist has explained the various types of implants used in dentistry and I have been informed of the alternatives to dental 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 (through). The implant type recommended for my specific condition is an endosteal dental implant.

1. I 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 my having the bone grafting and other surgical procedures which would be necessary for the placement of root form implants. I understand that the risk associated with the use of a subperiosteal implant is the failure and loss of the implant which could further reduce the minimal amount of existing bone which 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 which might arise involving the subperiosteal implant. I promise 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 not maintaining 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 non-treatment risks include, but are not limited to: (a) maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but likely, progressive dissolution of the underlying denture-supporting jaw bone; (b) any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time; (c) drifting, tilting and/or extrusion of remaining teeth; (d) looseness of teeth, periodontal disease (gum and bone), possibly followed by extraction (s); (e) a potential jaw joint problem (TMJ) caused by a deficient, collapsed or otherwise improper bite; and/or (f) limited oral function

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 post surgical 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), limited oral function, inflammation, swelling, infection, post operative pain, discoloration, numbness (exact extent, location and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing, persistent opening requiring other surgical procedures, injury to the teeth, TMJ (jaw) problems, poor 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 am aware that if the dental implant fails that dental implant removal surgery and/or further corrective surgeries associated with the removal may be required I understand that these complications can occur even if all dental procedures are done properly. I have also been advised that there is risk that the dental implant or restoration attached to the dental implant may break which could require additional procedures including but not limited to the surgical removal of the dental implant.

6. I have been advised that the use of tobacco, alcohol or sugar consumption may effect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the 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 am supposed to do at home will be, at a 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 that he/she has discussed with me, circled below, and their potential sides effects, specifically (local) (IV sedation) or (general). I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the effects of the anesthesia or drugs given for my care. My dentist has also discussed the various kinds and types of bone augmentation material, and I have authorized him/her to select the material which he/she believes to be the best choice for my implant treatment.

9. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or I.V. sedation, I further authorize and direct my dentist, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including additional and/or alternate treatment pertinent to the success of the comprehensive treatment plan and possibly, 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/her professional judgment, decides it is in my best interest to do so.

11. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, 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 on my medical history questionnaire. 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 or type for any mental or emotional condition. If I am currently in for any health problems, I certify that I have discussed the proposed implant surgery with my health care provider and have received his or her consent to undergo the dental implant procedure.

12. I authorize my dentist to make photos, slides, x-rays or any other visual aids 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 which 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 post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences which result from not following my dentist's advice.

15. The alternatives to dental implant surgery and restoration have been explained to me, including their risks and benefits. I have considered these alternative treatments and their risks and I have chosen dental implant surgery and restoration. The type of final restoration that will attach to the dental implant(s) has been explained to me and I consent to the placement of dental implant(s) under the gums and in the bone. I understand the dental implant surgery procedure.

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 FULLY REVIEWED THIS CONSENT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT 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 AND RELATED SURGERY, INCLUDING ANY ANCILLARY BONE GRAFTING PROCEDURES

Patient Signature

Date:

Witness Signature

Date:

Parent or Guardian, if Patient is a Minor

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