



D4-CONSENT-  
IMPLANT PLACEMENT

## PROCEDURE INFORMATION

**PATIENT NAME:**

LAST

FIRST

MI

DATE OF BIRTH

**PROCEDURE:**

**DENTAL EXTRACTION**

PROCEDURE

TEETH (S)

**DOCTOR NAME:**

LAST

FIRST

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

## DETAILS OF CONSENT

### Condition

My doctor has explained the nature of my condition to me: Unrestorable, non-functional teeth or financial reasons

### Procedure – Dental Implant

My doctor has proposed the following procedure to treat or diagnose my condition: Dental implant, This means: Surgically place an implant into the supporting jawbone.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of dental procedures and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to ask the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental professionals.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct the doctor and his assistants to treat my condition.
2. The procedure I choose to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials of human, animal or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage and retention for these teeth.
3. I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a bridge, a partial denture, full denture, or other options. I understand and choose to undergo the placement of root form implant(s).
4. I understand that my gum tissue will surgically be opened to expose the bone and that implants will be placed immediately by tapping or threading them into holes that have been drilled into my jaw bone. I understand that the gum tissue will then be stitched closed over or around the implant to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that the implants placed will be integrated in 3 to 6 months time, depending on my personal healing ability.
5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure contained herein. I therefore authorize and request that the doctor and his assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.
6. I have had the opportunity to discuss with the doctor the planned surgical procedure, implant placement, and my postoperative responsibilities. I understand that following the procedure during the healing process I

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**should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two weeks.** I should take any antibiotics prescribed and use pain medication as needed. If I experience an unusual amount of pain I should contact the doctor or his office immediately, as it may signify a problem.

7. I understand that anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol, and that I must not operate a motor vehicle or any other hazardous equipment while taking these drugs. Further, I agree not to operate a motor vehicle or any other hazardous equipment for at least 48 hours after my release from surgery.
8. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there exists a risk of failure or necessity of additional treatment despite appropriate care. I have been advised that the placement of root form implants has shown long term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. I further understand that should removal be required, the doctor will remove the implant at no additional cost. However, should I elect to have another doctor remove the implant, I am solely responsible for all costs and fees incurred in doing so and hereby release the doctor from any such costs and fees imposed by the other doctor.

### **Alternatives**

My doctor has explained the following medically acceptable alternatives to be: A bridge, a partial denture, full denture, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done.

### **Consequences of not having procedure**

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me. If I don't have the procedure, the following may also happen: Further loss of supporting tissues or bone. A gap in the teeth.

### **Other procedures**

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

### **Risks**

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: Restricted mouth opening; gum shrinkage; clicking or pain of the temporomandibular joints (jaw joints) tooth sensitivity to hot or cold for days up to months; loose teeth; food lodging between the teeth requiring flossing for removal; and unaesthetic exposure of crown margins of teeth in the surgery area. These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Interference with speech sounds; permanent nerve injury possibly requiring nerve graft surgery.

There will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. Should removal be required, the doctor will remove the implant at no additional cost. If I have someone else remove the implant, I am responsible for all costs and fees and will not ask the doctor to pay for it.

### **Drugs, Medications, and Anesthesia**

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

### **Implant Database**

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If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes.

### **No guarantee**

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

## **MY RESPONSIBILITY**

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

**Necessary Follow-up Care and Self-Care.** Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

## **MISCELLANEOUS**

### **Photography**

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

### **Miscellaneous**

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

### **Fees**

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

## **SIGNATURE**

### **DENTIST 4**

## Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

**Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.**

I authorize Dr. \_\_\_\_\_ to perform the procedure listed in the title above.  
I know that I am free to withdraw from treatment at any time.



\_\_\_\_\_

**Patient or Representative Signature**

\_\_\_\_\_

**Date**

If not the patient, what is your relationship to the patient?

\_\_\_\_\_

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.



\_\_\_\_\_

**Dentist Signature**

\_\_\_\_\_

**Date**

Consent for Extraction of Teeth  
ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION  
State law requires that you be given certain information and that we obtain your consent prior to beginning any surgical dental treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment, and the feasible treatment alternatives; that you have been given an opportunity to ask questions; that all your questions have been answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain.  
CONSENT FOR Tooth Extraction  
I hereby authorize and direct Dr. \_\_\_\_\_ to perform surgical tooth extraction (or upon any person identified above as the patient, for whom I am empowered to consent)  
Tooth

# \_\_\_\_\_ . Location(s) \_\_\_\_\_

\_\_\_\_\_. I understand that it may be necessary to place sterilized human bone matrix to help augment the extraction socket for future dental implants, bridges or dentures. Extraction of teeth is an irreversible process and whether routine or difficult is a surgical procedure. We will do everything we can to make sure your treatment is problem free. As in any surgery, there are some risks.

These risks include, but are not limited to:

1. Swelling and or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking and bruising.
3. Possible infection requiring further treatment.
4. Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care, it is more common from lower extractions, especially wisdom teeth.
5. Possible damage to adjacent teeth, especially those with large fillings or caps.

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6. The lower back teeth are adjacent to a large nerve. Numbness or altered sedation in the teeth, lip, tongue and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or injured. Sensation most often returns to normal, but in rare cases, the loss may be permanent.

7. Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is the result of jaw joint discomfort (TMJ), especially when TMJ disease and symptoms already exist.

8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.

9. Sharp ridges or bone splinters may form later at the edge of the socket. These may require another surgery to smooth or remove them.

10. Incomplete removal of tooth fragments – to avoid injury to vital structures such as nerves or sinuses, sometimes small root tips may be left in place. Sinus involvement: The roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or an opening may occur into the mouth which may require additional care.

11. The upper back teeth can be very close to the sinus. In rare instances a communication between the sinus and the extraction socket can occur. In extremely rare circumstances a tooth or part of the tooth can be pushed into the sinus. All these situations are fully manageable.

12. Most procedures are routine and serious complications are not expected. Those, which do occur, are most often minor and can be treated.

I hereby state that I have read and I fully understand this consent form. I have been given an opportunity to ask any questions I might have had, that those questions have been answered in a satisfactory manner. Date

\_\_\_\_\_ Time

\_\_\_\_\_ Signature

\_\_\_\_\_ (Signature of relative or Representative) Witness

\_\_\_\_\_