I, _____, hereby authorize and request _____ and/or his designees, to perform the following oral and maxillofacial procedures upon me:

_____

And in the event of unforeseen circumstances, I consent to the performance of such additional and alternative procedures as in the judgment of the above doctors(s) may be necessary to restore and/or preserve my overall health.

1. IMPLANT SUCCESS. I understand that for implants to be successful, they must bond directly to the jawbone (called osseointegration). It has been explained to me that implants are not 100 % successful and that the success or failure of my implants(s) will determine the final design of the restorations(s) placed in my mouth and whether the restorations(s) will be permanently fixed to the implants or will be removable by me.
2. TREATMENT. I understand that the initial surgical procedure may or may not involve making an incision in the gums and exposing the underlying jawbone. Holes are then drilled into the bone and the implant(s) are placed into these holes. The gums are then stitched closed, if needed, and the area allowed to heal for a variable period of time (3-6 months or more). I understand that I may have to avoid wearing my denture(s) for 1-2 weeks after this first surgery and then use them carefully for several weeks until healing is complete. After the healing period, a second surgical procedure may be needed to expose the implants and attach extensions on them which will eventually support the restoration(s). Shortly after this second surgery, the prosthodontic phase of my treatment will take place which will involve several appointments.
3. ALTERNATIVES TO IMPLANTS. I have considered the following alternative to implant treatment:

    1. No treatment.
    2. Construction of conventional complete or partial denture(s).
    3. Tooth replacement with conventional bridgework supported by my remaining natural teeth (if possible).

4. RISKS OF IMPLANT TREATMENT. I have been informed and I understand that the risks of no treatment include, but are not limited to, continuing use of removable partial or complete dentures with associated potential for discomfort and shrinkage of the jawbones which would require periodic relining or remaking of the denture(s), periodontal disease which could lead to the loss of any remaining teeth if not treated.

    I understand that surgical risks include, but are not limited to, infection, bleeding, adverse drug reactions, discomfort, bruising, perforation of the sinus floor or floor of the the nose, damage (transient or permanent) to the nerve that gives feeling to the lower lip which could result in numbness or tingling or other sensations in the lower lip, bone fracture, jaw joint injury, or loss of one or more implants.

I understand that prosthodontic risks include, but are not limited to, failure of an implant to osseointegrate(fuse to the bone), which may be immediate or delayed, fracture of the restoration and/or implant components, wear of the restoration and/or implant components, wear of the restoration requiring remake, comprised aesthetic or functional outcome as a result of implant loss or less than ideal angulation or position of the implant(s).

I understand that my tongue will need to adapt to changes in my teeth, which may affect my speech until the tongue accommodates the change.

I understand that failing implants would require surgical removal and may require additional prosthodontic procedures and/or the subsequent placement of additional implant(s).

5. TEMPORARY TEETH: I understand that Advanced Dentistry will make every effort to provide me with some type of temporary tooth/teeth during the healing phase after my implant surgery. I understand this may be accomplished with a removable appliance or with a temporary crown or bridge, which is not removable.

   Since the first 4-6 weeks after my implants are placed is the most critical time, I also understand that in some cases I will not be able to have temporary teeth until my implant has fully integrated into the bone.

6. RISKS OF SMOKING. I understand the harmful effects of smoking and have been advised that I cease smoking prior to surgery in order to prevent the toxic chemical effects on healing tissues. I also understand that it has been recommended that I should discontinue the use of tobacco until the final prosthesis is delivered. This is the biological rationale and any deviation from this could jeopardize the success of my dental implants.

7. NO GUARANTEE. No guarantee or warranty of any kind has been made to me that the proposed implant treatment will be 100% successful or that the final restoration(s) will be totally successful from a functional or aesthetic (appearance) standpoint. I understand that no medical or dental procedure is totally predictable and that this includes treatment with dental implants. I understand that because of unknown or unforeseen factors, further surgical and prosthodontic procedures beyond those described to me might be necessary. I also understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene procedures directed and that I return for scheduled follow-up and recall appointments.

   I have had the opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby consent to the placement of implants in my mouth and the associated prosthodontic procedures for restoring the implants.

I have read and understand the treatment described and I have no additional questions.

_____

Initial here!

PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ THIS CONSENT AND THAT I FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO THE PROCEDURE. I UNDERSTAND THE THE EXPLANATION REFERRED TO OR MADE. ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN, AND IN APPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

PATIENT'S SIGNATURE DATE

PARENT OR LEGAL GUARDIAN (IF UNDER 18) DATE

WITNESS (PROFESSIONAL STAFF MEMBERS) DATE

PROSTHODONTIST DATE