DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

CONSENT FOR TWO-STAGE OSSEOUSINTEGRATED IMPLANT SURGERY

You have the right to be given information about your proposed implant placement so that you are able to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is your acknowledgement that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____

Patients Name Date

___1. I hereby authorize Dr. _____ and assistants to treat the condition described as _____
_____.

___2. The procedure offered to treat the condition has been explained to me and I understand the nature of the procedure to be: _____
_____.

____3. I understand that incisions will be made in my mouth for the purpose of placing one or more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge, or denture. I acknowledge that the doctor has explained to me the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge or denture that will be attached to this implant(s) will be made and attached by Dr._____ and that a separate charge will be made by the office.

____4. I understand that the implant(s) may need to remain covered by gum tissue for at least three months before being used and that a second surgical procedure maybe required to uncover the top of the implant. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted, **the entire treatment plan must be followed and completed on schedule.** If the planned schedule is not carried out , the implant(s) may fail.

_____5. I have been informed of possible alternative methods of treatment (if any), including: _____
_____
_____
I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

_____6. My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include but are not limited to:

_____A. post-operative discomfort and swelling that may require several days of at-home recuperation.

_____B. Prolonged or heavy bleeding that may require additional treatment.

_____C. Injury or damage to adjacent teeth or roots of adjacent teeth.

_____D. Post-Operative infection that may require additional treatment.

_____E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.

_____F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

_____G. Injury to nerve branches in the lower jaw resulting in numbness, pain or tingling of the chin, lips, cheek, gums or tongue on the operated side(s). These symptoms may persist for several weeks, months or, in rare instances may be permanent.

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_____H. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally entered (sinus-lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.

_____I. Fracture of the jaw or perforation of thin bony plates.

_____J. use of other materials which may have to be removed at a later date: _____

_____K. Bone loss around implants.

_____L. implant or prosthesis fracture, or loss of the implant due to rejection by the body.

_____M. other_____

____7. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from that set forth in paragraph 2 above. I authorize my doctor and his staff to perform such additional procedures as are necessary and desirable in the exercise of professional judgment.

_____8. I consent to the administration of anesthesia I have chosen, which is:

☐ Local

☐ Local with Nitrous Oxide / Oxygen Analgesia

☐ Local with oral Premedication

☐ Local with Intravenous Sedation

☐ General Anesthesia

_____9. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and / or disability, and may require special care. Nausea and vomiting, although are rare, may be unfortunate side affects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

_____10. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

A. because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

C. you must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING.**

D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) Or any other medications provided by this office, **using only a small sip of water.**

_____11. I understand that no guarantee can be promised and I give free and voluntary consent for treatment,

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CONSENT
My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read, and write English.

BEFORE SIGNING, PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

_____

Patient's (or Legal Guardian's) Signature **Date**

_____

Doctors Signature **Date**

_____

Witness' Signature **Date**