Dental Implants
Information & Consent Form

Patient Name:_____ Patient DOB:_____

Date:_____ Tooth Number:_____

-Please Read and Initial the Following-

_____ I have been informed and afforded the time to fully understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

_____ My doctor has carefully examined my mouth. Alternatives to this treatment (i.e. fixed bridges, partial dentures, no replacement) have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

_____ I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of the vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

_____ I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done, an inability to place implants at a later date due to changes in oral and medical conditions could exist.

_____ My doctor has explained that there is no method to predict accurately the gum and the bone healing capabilities in each patient following the placement of the implant

_____ It has been explained that in some instances implants fail, which might require further corrective surgery or the removal of the implant. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as the outcome of the results of treatment or surgery can be made.

_____ In understand that excessive smoking, alcohol, or blood sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

_____ I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more, until fully recovered from the effects of the anesthesia or drugs given for my care.

_____ To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

Dental Implants
Information & Consent Form

CANYON LAKES DENTAL

-Dental Implants Information & Consent Form Cont.-

_____ I request and authorize medical/dental services for myself, including implants and other surgery. I fully understand the contemplated procedure, surgery, or treatment conditions that may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from now contemplated; I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.

_____ I have been informed of the overall treatment fee and agree to the payment of such fees. Should fees change due to unforeseen circumstances, I will be informed of the changes in fees and approve the changes before additional dental care is rendered.

Patient's Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____