ORANGE PERIODONTICS
AND DENTAL IMPLANTOLOGY

Richard K Parris DDS, Sepi Lee DDS MS, Cliff Lee DMD MS

## CONSENT FOR THE PLACEMENT OF DENTAL IMPLANTS

*An explanation of your need for dental implants, their purpose and benefits, the surgeries related to their placement and exposure, and the possible complications as well as alternatives to their use was discussed with you at your consultation. We obtained your verbal consent to undergo the implant surgical treatment planned for you. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.*

**Purpose of Implants:** I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

**Alternative Treatment:** Reasonable alternatives to implants have been explained to me. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

**Type of Implant:** I am aware that the type of implant to be used on me is one which is placed into the jaw bone; that this is done by first reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone, and covering the bone and implant with the gum flap.

**Surgical Procedures:** I understand that multiple surgeries may be necessary: one to insert the implant(s) as described above, and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge, or denture. I also understand that sometimes it is beneficial to add gum tissue or bone graft material to the implant site either prior to implant placement or after the implant(s) has healed.

**Risks:** Risks related to this surgery include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloring, perforation of the upper jaw sinus or nasal cavity during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth, or chin, jaw joint injuries or associated muscle spasms, bone fractures, and slow healing. Prosthetic risks include, but are not limited to, unsuccessful union of the implant(s) to the jaw bone, and/or stress metal fracture of the implant(s). Risks related to the anesthetics include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness and/or discoloration or blockage along a vein at the injection site.

**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant(s) will be retained, but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long-term success cannot be promised.

**Consent to Unforeseen Conditions:** During treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating doctor.

**Compliance with Self-Care Instructions:** I understand that excessive smoking and/or alcohol intake and improper oral hygiene and/or diet may affect gum healing and may limit the successful outcome of

my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored, and the doctor can evaluate and report on the success of the surgery.

**Implant Complications and Failure:** I understand that implants can fail to integrate into the bone and may need to be replaced. I understand that implants placed in the mouth are subject to biological processes such as disease (peri-implantitis), and that the long-term success of implants is dependent on proper and sufficient oral hygiene and care, periodic examinations, and professional cleanings, as well as other factors such as systemic illnesses, smoking, trauma, radiation, medications, etc.

**Supplemental Records and Their Use:** I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

**Patient's Endorsement:** My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

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| Patient's Signature | Date | Patient's Name |

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| Signature of Witness | Date |