

# CONSENT FOR DENTAL IMPLANT SURGERY

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Patient's Name

Date

**If you have any question, please ask your doctor BEFORE signing.**

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 to proceed with surgery. What you are being asked to sign is your acknowledgment that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments.

I hereby authorize Dr. Laskarides and assistants to treat the condition described as:

The procedure(s) offered to treat the condition has been explained to me and I understand the nature of the procedure(s) to be:

This surgical procedure may consist of multiple separate procedures.

I have been informed of possible alternative methods of treatment (if any), including no treatment, new removable appliances, crowns and bridges, and:

The risks and benefits of these choices have been presented to me.

I understand that incisions will be made inside my mouth for the purpose of placing one or more endosteal (inside the bone) 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 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 later be attached to the implant(s) will be made and attached by Dr. Samiei and that a separate charge will be made by that office.

I understand that the implant(s) may remain covered by gum tissue for some months before being used and that a second surgical procedure is 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.

I further understand that if clinical conditions turn out to be unfavorable for the use of the implant(s) or prevent the placement of implants, my doctor will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants.

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Expected Benefits: The purpose of the dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and/or retention for these teeth.

Prosthodontic Phase of Procedure: I understand that at this point I will be referred back to my restorative dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthodontic device will be attached to the implant. This procedure should be performed by a person trained in the prosthodontic protocol for the root form implant system.

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. I understand that some patients do not respond successfully to dental implants, and in such cases, the implant(s) may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur. I also understand that if an implant fails within one year, the surgeon might recommend replacement at no cost only if clinically indicated. **Refunds are not given for failed implants. If other procedures are required to make the replacement surgery possible, they may not be done at no-cost.**
- B. Post-operative discomfort and swelling that may require several days of at-home recuperation.
- C. Prolonged or heavy bleeding that may require additional treatment.
- D. Injury or damage to adjacent teeth or roots of adjacent teeth.
- E. Transient, but on occasion, permanent increased tooth looseness and/or tooth sensitivity to hot, cold, sweet, or acidic foods.
- F. Shrinkage of the gums upon healing resulting in elongation of some teeth and greater spaces between some teeth. Scarring of the gum.
- G. Post-operative infection that may require additional treatment.
- H. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
- I. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
- J. Injury to nerve branches in the jaw or soft tissues 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.
- K. Opening into the nasal cavity or the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. Infection of the sinus may require certain medications, additional surgery, and additional recovery time.
- L. Fracture of the jaw or perforation of thin bony plates.
- M. Delayed healing.
- N. Accidental swallowing of foreign matter.
- O. Use of other implanted materials which may have to be removed at a later date.
- P. Bone loss around implants.

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- Q. Implant or prosthesis fracture, or loss of the implant due to rejection by the body.
- R. Local anesthesia, medications, drugs, anesthesia, and prescriptions may cause allergic reactions, complications, and side effects. They carry the potential risks of brain damage, stroke, heart attack, or death.

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 above. I authorize my doctor and his staffs to perform such additional procedures as are necessary and desirable in the exercise of professional judgment.

I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in the procedure.

I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

Continued wearing of ill-fitting and loose removable dental appliances can result in damage to the implant(s) and bone. I understand that I need to follow my doctor's instruction and may not be able to wear my denture(s) for an extended period of time during healing.

I understand smoking is extremely detrimental to the success of implant surgery. I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery, including the later uncovering procedure, and to make strong efforts to give up smoking entirely.

I understand that no guarantee of treatment results can be promised and I give my free and voluntary consent for treatment.

Necessary Follow-up Care and Self Care: I understand that it is important for me to continue to see my doctor. Implants, natural teeth, and prostheses have to be maintained daily in a clean, hygienic manner. Implants and prosthesis must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my treating dentists.

The anesthetic I have chosen for my surgery is:

- Local Anesthesia
- Local Anesthesia with Oral Pre-medication
- Local Anesthesia with Intravenous Sedation (Requires separate consent)
- General Anesthesia (Requires separate consent)

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Medications, drugs, anesthesia, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been

advised not to operate any vehicle or hazardous devices, do anything that requires attention, or work while taking these medications and/or drugs until fully recovered.

Photographic, video-graphic, and other records: I authorize the taking, viewing, and publication of photos, slides, x-rays, videos, or any other records of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

### **GRAFTING**

On occasion a area of the jaw may not have enough bone or gum for the planned dental implant and requires adding a bone and/or gum graft harvested within your month, donated from another individual, made from an animal source, and/or man-made. There are certain risks associated with these procedures and materials:

### **GENERAL RISKS OF BONE GRAFTING**

- A. Bleeding, swelling, or infection at the donor site requiring further treatment.
- B. Allergic or other adverse reaction to drugs used during or after the procedure.
- C. The need for additional or more extensive procedures in order to obtain sufficient bone for grafting.

### **RISKS AND COMPLICATIONS OF GRAFTING WITH BONE FROM WITHIN THE MOUTH AREA**

- A. Damage to adjacent teeth, which may require future root canal procedures, or may cause loss of those teeth.
- B. Alteration of the gum and tooth structure in adjacent areas which could cause a cosmetic or functional problem.
- C. Numbness or pain in the area of the donor or recipient site, or more extensive areas, which may be temporary or permanent.
- D. Penetration of the sinus or nasal cavity in the upper jaw which could result in infection or other complication requiring additional drug or surgical treatment.

### **RISKS OF DONATED BONE and SOFT TISSUE, MATERIALS DERIVED FROM ANIMAL SOURCE, MAN-MADE BONE AND SOFT TISSUE, and METALLIC/MAN-MADE IMPLANT AND SCREWS**

Usually, additional material is used to supplement the patient's own tissue, or to spare an extensive donor site surgical procedure. Sometimes a membrane material is used to cover a bone graft or implant. These materials include tissue from another individual, materials made from animal, man-made, or derived from natural sources such as coral. Use of such material may involve separate risks including, but not limited to:

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- A. Rejection of the donated graft material together with the entire graft.
- B. The remote chance of disease transmission from processed human or animal materials.

C. The potential need for removal of the metallic/man-made implant and screws.

I understand that in my grafting procedure, my own bone is taken from (note anatomic area) \_\_\_\_\_, with the possibility of bone from another area: \_\_\_\_\_. I specifically request NOT to use the following type(s) of bone or implant material \_\_\_\_\_

**CONSENT**

I have been fully informed of the nature of dental implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available along with their risks and benefits, and the necessity for follow-up care and self care. I have had an opportunity to ask any question I may have in connection with the treatment and to discuss my concerns. After thorough deliberation, I hereby consent to the performance of dental implant surgery.

I also consent to use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my doctor's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts or membranes to build up the ridge of my jaw and thereby assist in placement, closure, and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

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