Lakeshore **W**est **D**ental
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IMPLANT SURGERY CONSENT

Patient Name: ____

1. I have been informed and afforded 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.
2. I have been informed that Dr. Sam Patel is a general dentist and a referral to a specialist (oral surgeon) has been offered.
3. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. These alternatives are a Bridge or Dentures. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
4. I have further been informed of the possible complications and risks involved with surgery, drugs and anesthesia. I understand and accept these possible complications and risks. Such complications can include but are not limited to 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 veins, injury to present teeth, bone fracture, sinus penetration, delayed healing, allergic reaction to drugs or medication used.
5. I understand that if nothing is done any of the following could occur: bone loss, gum tissue inflammation, infection, sensitivity and looseness of teeth followed by necessary extraction. Also possible are temporomandibular joint (jaw) problems, headaches and referred pains 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 or medical conditions could exist.
6. My doctor has explained that there is no method to predict accurately the gum and bone healing capability in each patient following the placement of the implant. In general a healing time of 3-6 months is normal. There are instances where implant treatment may not succeed. Alternatives will then be readdressed.
7. It has been explained to me that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome or results of the treatment or the surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.
8. I understand that excessive smoking; alcohol use or blood sugar problems may affect gum and bone 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.
9. I agree to the anesthesia, depending on the choice of my doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more or until fully recovered from the effects of the anesthesia or drugs given for my care.
10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergies or unusual reactions to drugs, insect bits, anesthetics, pollen, dust, blood or body disease, gum or skin reaction, abnormal bleeding or any other conditions related to my health.
11. I consent to photography, filming, recording, x-rays and additional professional staff observing the procedure to be preformed for the advancement of implant dentistry, provided my identity is not revealed.

Patient Initial ______

12. I agree to notify my doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (2-4wks).
13. I request and authorize medical/dental services for myself, including implants and other surgery. I fully understand the contemplated procedure. I approve any modifications in design, material, or care, if it is felt this is for my best interest. If an unforeseen conditions arise in the course of the treatment which calls for the procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, associates or assistants, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.
14. In rare instances implant treatment does not succeed including the surgery or prosthetics due to biological factors beyond our control or ability to predict. As such the fee paid is non refundable. In these circumstances we may offer alternative treatment at a reduced fee. The patient is still responsible for any materials cost incurred with the additional treatment. This in no way implies that we have provided inadequate professional treatment but our desire to see you have the best possible outcome.

Patient____ Date________________

Witness____ Date________________

Dentist____ Date________________