Periodontal & Implant EXCELLENCE

PRACTICE LIMITED TO PERIODONTICS, IMPLANTS & COSMETIC PERIODONTICS

# CONSENT FOR ROOT FORM DENTAL IMPLANTS

## Diagnosis

After a careful examination and study of my dental condition my periodontists has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by implants.

## Recommended treatments

In order to treat my condition, my periodontist has recommended the use of root form dental implants. I understand that the procedure for root form implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.

## Surgical phase

I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase. I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my periodontist will make a professional judgement 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. For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance can then begin.

## Principal Complications

I understand that some patients do not respond successfully to dental implants, and in such cases, the implants may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success varies among patients. I understand that complications may result from the implant surgery. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and may be irreversible. I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection or integration between the implant and the bone/tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, or at any time thereafter.

## Necessary follow- Up Care

I understand that is important for me to continue to see my periodontist for follow up care and periodontal maintenance. Implants, natural teeth and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances 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 to me by my periodontist.

## No Warranty or Guarantee

Due to individual patient differences, periodontist cannot predict with absolute certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of teeth, despite the best of care.

# PATIENT CONSENT

I HAVE BEEN FULLY INFORMED OF THE NATURE OF ROOT FORM IMPLANT SURGERY, THE PROCEDURE TO BE UTILIZED, THE RISKS AND BENEFITS OF THE SURGERY, THE ALTERNATIVE TREATMENTS AVAILABLE, AND THE NECESSITY FOR FOLLW UP AND SELF CARE. I HAVE HAD AN OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE IN CONNECTION WITH THE TREATMENT AND TO DISCUSS MY CONCERN WITH MY PERIODONTIST.
I HEREBY CONSENT TO THE PERFORMANCE OF DENTAL IMPLANT SURGERY AS PRESENTED TO ME DURING CONSULTATION AND IN THE TREATMENT PLAN PRESENTATION AS DESCRIBED IN THIS DOCUMENT.
I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

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

Patient Signature _____ Date _____

Witness _____ Date _____

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