TWO-STAGE OSSEO-INTEGRATED IMPLANT SURGERY

A dental implant is an artificial tooth root replacement used to support restorations that resemble a tooth or group of teeth. The osseo-integrated implant uses titanium fused into the bone so bone cells grow on and into the rough surface of the implanted titanium. This forms a structural and functional connection between the living bone and the implant. A variation on the implant procedure is the implant-supported bridge or implant-supported denture.

Patient’s Initials

The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.

I understand and accept that the most likely material risks and complications of two-stage osseo-integrated implant surgery have been discussed with me and may include but are not limited to:

- Several days of swelling and discomfort, which may require staying at home before resuming normal activities.
- Bleeding, which can at times be heavy or prolonged and can occasionally require additional treatment.
- Injury to the nerves, which provide the feeling to the mouth and/or facial tissues. This can result in a tingling sensation, numbness, pain, or other sensations that can affect the chin, lip, cheek, tongue, and gums, including loss of taste. The sensations may persist for weeks or months and can occasionally be permanent.
- Injury or damage to the adjacent teeth and tooth roots in the area of the implant placement. Such damage can sometimes require root canal treatment, gum treatment, and, occasionally, tooth extraction.
- Postoperative infection, which may require additional treatment.
- Fracturing of the jaw, which may require additional treatment.
- Artificial bone or bank bone particles and/or membranes placed at surgery and used to support and protect the implant may require removal.
- During placement of implants in the back portion of the upper jaw, the sinus may be entered and additional treatment required.
- Stretching and cracking at the corner of the mouth that may heal slowly.
- Limited mouth opening due to muscle stretching and stress on the jaw joints (TMs).
- The implant(s) may not “take,” necessitating removal of the implant(s).
- Bone loss may develop around the implant(s) and require additional treatment or removal of the implant(s).
- The implant(s) or overlying bridge may fracture, which can lead to loss of the implant(s).

I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.

I understand and accept the risks of blood transfusion(s) that may be necessary (if applicable).

I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The surgeon will do his/her best to minimize scarring but cannot control its ultimate appearance (if applicable).

I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

I have informed the surgeon of all my known allergies.

I have informed the surgeon of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

I am aware and accept that no guarantees about the results of the procedure have been made.

I have been advised of the probable consequences of declining recommended or alternative therapies.

I have been informed of what to expect postoperatively, including, but not limited to, estimated recovery time, anticipated activity level, and the possibility of additional procedures.
I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).

Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending surgeon (if applicable).

The surgeon has answered all of my questions regarding this procedure.

Information for Female Patients:

I have informed my surgeon about my possible use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate mechanical forms of birth control during the period of my treatment and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, DDS/DMD/MD, with associates or assistants of his or her choice, to perform the procedure of ___________________ on ___________________ at ___________________ on the ___________________.

(procedure name) (patient name) (facility name) (right, left, level, body part)

I further authorize the surgeon(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Surgeon Signature/Date/Time

__ copy given to patient

__ original placed in chart

initial

initial