**IMPLANT SURGERY**

*A dental implant is an artificial tooth root replacement used to support restorations that resemble a tooth or group of teeth.*

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Patient’s Initials

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

_____ I understand the steps necessary to accomplish the placement of the implant into my jawbone. My surgical implant care may involve two stages: the first for installation of the fixture to my jawbone, and the second to uncover the fixture so that an abutment can be connected to the implant. The abutment projects from the top of the implant through the gum tissue, into my mouth.

_____ My mouth has been carefully examined. Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me. I have tried or considered these methods, but desire an implant as a means to help secure the replacement of missing teeth.

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

- Pain
- Swelling
- Infection
- Bruising
- Numbness of the lip, tongue, chin, cheek, or teeth
- Alteration in taste
- Injury to teeth
- Bone fractures
- Sinus penetration
- Delayed healing
- Failure in implant, resulting in need for removal or possible bone loss
- Affected speech
- Potential soft tissue surgery
- Visible implant

_____ I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, looseness, or drifting teeth followed by necessity of extraction. Also possible are temporomandibular joint (TMJ) problems.

_____ 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 treatment or surgery can be made. I am aware and accept that no guarantees about the results of the procedure have been made.

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

_____ I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent that warrant—in the judgment of my surgeon—additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care if it is felt to be in my best interest.

_____ 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 occasionally speech can be affected by the placement of implants. I am aware that further soft tissue surgery is sometimes necessary to improve the relationship of the soft tissue to the implant. I am also aware that the implant might be visible.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications *(if applicable).* I understand that excessive smoking, use of alcohol, or sugar may affect gum healing and may limit the success of my implant. I agree to follow my doctor’s home care instructions and report to my dentist for regular examinations as instructed. I realize that my own proper hygiene is critical to the future success of my implant and that I must maintain good oral hygiene. Like normal dentition, implants may be affected by lack of oral hygiene and can actually be lost due to neglect.

_____ 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. To my knowledge, I have given an accurate report of my physical and mental health history, including any prior allergic or unusual reaction to drugs, food, insect bites, anesthetics, pollens, dust, abnormal bleeding, or any other condition.

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

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.

It has been explained to me that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of implants.

It has been explained that, in some instances, implants fail and must be removed. I understand that sometimes implants are placed and not used. I understand if implants are lost, they can usually be replaced after the bone heals. There can also be bone loss with the failure of an implant.

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).

I agree to the type of anesthesia—local or general—administered intravenously, intramuscularly, orally, or by inhalation. I agree not to operate a motor vehicle or hazardous device for at least 24 hours (or more) until I am fully recovered from the effects of anesthesia or drugs given for my care. I am aware that possible anesthesia risks include inflammation of veins and allergic reactions caused by my drugs or medications.

I am satisfied that the doctor has answered all of my questions regarding this procedure and that I understand all the terms of this agreement.

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