

# DENTAL IMPLANT CONSENT FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

You have the right and the obligation to make decisions regarding your health care. Your dentist can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. **AUTHORIZATION.** I request and authorize Dr. \_\_\_\_\_ or his/her associates or assistants to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

Dental implants are metal anchors put inside the jawbone underneath the gum line. Small posts are attached to the implants and artificial teeth or dentures are fastened to the posts.

Most patients need two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. A temporary denture may be worn for a few months while the anchors bond with the jawbone and the gums and bone heal. The second procedure will uncover the implants to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of fixed or removable bridgework or a denture, are fastened to the posts. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also might be necessary to install the anchors and posts. The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures.

I authorize placement of implants in the following areas of teeth:

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2. **ALTERNATIVE TREATMENT.** I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks, and complications which have been explained to me.
3. **ANESTHESIA AND MEDICATION.** I consent to the administration of anesthesia or other medications before, during, or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications include the very rare potential of risks or complications, such as damage to vital organs including the brain, heart, lungs, liver, and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.
4. **RISKS.** I understand that there are potential risks, complications, and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication, and side effect, I have been informed of some of the possible risks, complications, and side effects of dental implant surgery. These could include, but may not be limited to, the following:

- Postoperative pain, discomfort, and swelling.
- Bleeding.
- Postoperative infection.
- Injury or damage to adjacent teeth or roots of the teeth.
- Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling or pain of the chin, lips, cheek, gums, or tongue.
- Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw - temporomandibular joint (TMJ) syndrome.
- Fracture of the jaw.
- Bone loss of the jaw.
- Penetration into the sinus cavity.
- Mechanical failure of the anchors, posts, or attached teeth.
- Failure to implant itself.
- Allergic or adverse reaction to any medications.

Most of these risks, complications, and side effects are not serious and do not occur frequently.

Although these risks, complications, and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

These potential risks and complications could result in the need to repeat the procedures, remove the implants, or undergo additional dental, medical, or surgical treatment or procedures, hospitalization, or blood transfusions. Very rarely, the potential risks and complications could result in permanent numbness, disability, or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment as required.

- 5. CONSENT.** I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications, and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects, and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**Dentist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_