CONSENT FORM FOR DENTAL IMPLANTS

I, __________________________, hereby authorize Dr. ____________________ to perform surgery upon me to insert one or more dental implant(s) in my upper and/or lower jaw.

I acknowledge that the procedure has been explained to me in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant and the cost for that work is not included in the surgical charge for this. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant could remain covered under the gum tissue anywhere from 2-6 months or can be placed over the gum tissue as a one stage procedure based on the surgeon's discretion. I am aware that if the implant is covered by gum tissue a second surgical procedure will be required to uncover the top of the implant. I also understand that there will be no refund of the fees in the event of failure. It has also been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail. I'm aware that a localized sinus lift and bone grafting using donor or bovine freeze dried bone may be used along with implants being placed in the posterior regions of my upper jaw (maxilla) and the need for this will be at the surgeon’s discretion and that there will be an additional cost involved.

I understand that excessive smoking, alcohol or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor's homecare instructions. I agree to report to my doctor for regular examinations as instructed. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, dust, pollens, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I have been informed of the alternatives to use of a dental implant which may include no treatment at all; construction of a new ridge of my upper or lower jaw by means of bone grafting with synthetic, donor or bovine freeze dried bone grafts and in some instances bone from my own jaw with or without the use of a membrane. The advantages of each of the above procedures, if appropriate, have been explained to me and I choose to proceed with insertion of the dental implant(s).

I also authorize and direct the use of such additional services as he may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion or by other medically accepted route of administration; and the removal of bone, tissue and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices.

Initials _________
I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

If any unforeseen condition arises in the course of treatment which calls for performance of procedures in addition to or different from that now contemplated and I am under any form of sedation or anesthesia, I further authorize and direct whatever deemed necessary and advisable under the circumstance with the exception of ___________________________________________.

If no exceptions, write "none".________________________________________.

RISKS and COMPLICATIONS OF DENTAL IMPLANT SURGERY
A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
B. Prolonged or heavy bleeding that may require additional treatment.
C. Injury or damage to adjacent teeth or roots of adjacent teeth, possibly requiring Further root canal therapy, and occasionally the loss of an injured tooth.
D. Post-operative infection that may require additional treatment.
E. Stretching of the corners of the mouth that may cause cracking and bruising.
F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ).
G. Nasal or sinus penetration
H. Fracture of the jaw.
I. Possible injury to nerve branches in the bone resulting in numbness, pain or tingling of the lips, chin, cheek, gums or teeth. If implants are placed in the lower jaw, there may be numbness or pain of the chin or tongue also. These symptoms may persist for several weeks, months or, in rare instances, may be permanent.

Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, or necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period and that a charge will be made for this procedure. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

ANESTHESIA

The anesthesia I have chosen for my surgery is:

☐ local anesthesia
☐ local with nitrous oxide/oxygen analgesia
☐ local with oral pre-medication - Valium
☐ local with intravenous sedation
☐ general anesthesia

ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

Initials______
YOUR OBLIGATIONS IF IV ANESTHESIA IS USED

1. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and STAY with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours. A responsible adult must accompany the patient and REMAIN IN THE WAITING ROOM FOR THE ENTIRE TIME of the procedure. This person must be able to drive since the patient will be unable to drive for at least 24 hours after the anesthesia or sedation. Watch for Drowsiness.

2. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc. Do not drink alcohol.

3. You must have a completely empty stomach. HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE THREATENING.

4. Take your regular medications, the morning of surgery with sips of water only.

5. Loose clothes should be worn to facilitate the starting of an intravenous and the placement of monitoring equipment. Flat comfortable shoes should also be worn. Because your blood pressure will be monitored, you should wear a short sleeve shirt. Do not wear jewelry, watches, make-up, finger nail polish, or contact lenses.

6. If you have a severe cold, sore throat or sinus infection with infection with excessive drainage, sedation medications can not be administered. Please call the office if any of these symptoms develop prior to your scheduled appointment.

7. While taking antibiotics, Birth Control Pills, may become ineffective. Extra precautions should be taken while you are on antibiotics.

8. Fill any prescriptions prior to your appointment.

It has been explained to me that in the course of the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure, a different procedure from those set forth above, or abandonment of the procedure entirely. In such an event, I authorize my doctor and his staff to perform such procedures as are necessary and desirable in the exercise of professional judgment to complete my surgery.

It has been explained to me that a perfect result is not and cannot be guaranteed or warranted.

Initials__________
CONSENT
I certify that I speak, read and write English or have an Interpreter and have read and fully understand this consent for surgery, that all blanks were filled in prior to my initialing and signing this form and that all my questions were answered to my satisfaction.

<table>
<thead>
<tr>
<th>Patient’s (or Legal Guardian’s) Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Witness’ Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Interpreter’s Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

I