

MSMILINE CLINIC

INFORMED CONSENT DISCUSSION IMPLANT PLACEMENT

PATIENT'S NAME: _____ **DATE:** _____

Implant placement and restoration involves 2 major stages; surgical placement of the implant(s), followed by the restoration of the implant(s) after osseointegration (the bone grows around the implant) has occurred.

Dr. _____ will be placing the implant(s) which usually involve a 2 stage surgical procedure. A surgical informed consent discussion will take place with Dr. _____ and your questions will be answered.

Dr. _____ will be doing the restorative phase and specific questions regarding the prostheses (customized restoration) will be answered during the informed consent discussion.

The following is an outline of the discussion Dr. _____ and I had, regarding the surgical phase of the implant procedures.

PATIENT'S INITIALS REQUIRED

_____ Patient's condition: _____

_____ Test, models stents and/ or x-rays completed: _____

_____ Test, models stents and/ or other procedures to be performed: _____

_____ Referrals to specialist (if needed): _____

A healthy mouth with sufficient bone mass is required for successful implant results.

_____ I may require periodontal disease to be treated and controlled before implant surgery can begin.

_____ I may require extractions prior to or after the placement of implants.

_____ I may require root canal and crowns to be completed or retreated before implants are placed.

_____ I may require bone augmentation or tissue grafts before, during or after implants are placed.

_____ I understand that fees for referral treatments are separate and depend upon the referring dentist's fee schedule.

Alternative treatment plans to implants placement

OPTION 1: No replacement of missing teeth

_____ ***Risks, not limited to the following:*** compromised aesthetics and possible drift of adjacent and/ or opposing teeth into the space(s) with the resultant collapse of the arch integrity. **I understand** that if no treatment is elected an inability to place implants at a later date due to changes in oral or medical conditions could occur.

_____ ***Benefits, not limited to the following:*** no additional cost at this time.

_____ ***Consequences if no treatment is administered, not limited to the following:*** **I understand** that I can choose to do nothing and my present complaints will continue and may worsen. Subsequent choices for repair may become more difficult, expensive or not feasible.

OPTION 2& 3: Removable or Fixed Appliances

_____ Removable or fixed appliances without implants have been explained to me by Dr. _____ as an alternative to implant supported restorations. The risks, benefits and consequences of the 2 types of appliances were explained to me and **I understand** them.

Implant surgical treatment plan

Facts for consideration

_____ Dental implants are metal anchors placed into the jawbone, underneath the gum tissue, to support artificial teeth where natural teeth are missing. When the bone attaches itself to the implant, these implants act as tooth roots substitutes and form a strong foundation to stabilize the customized artificial teeth.

_____ ***I understand*** that the placement of implants and the making of compatible prostheses are 2 separate treatments with separate expenses and separate risks and benefits.

_____ ***I understand*** that in order for the implant to be placed in my bone, my gum tissue will be opened to expose the bone. Implants will be placed by pushing or threading them into holes made in the bone. The implants will have to be snugly fitted and held tightly into place during the healing phase.

_____ ***I understand*** that the soft tissue will be sutured closed over and around the implant. A periodontal bandage or dressing may be placed. Healing will be allowed for a period of 3 to 9 months.

_____ ***I understand*** that for those types of implants that require a second surgical procedure, the overlying tissues will be opened at the appropriate time and the stability of the implant will be tested. If the implant appears satisfactory, an attachment will be connected to the implant. The restorative phase to create a prosthetic appliance or crown(s) can begin.

_____ ***I understand*** that additional maintenance and repair may be expected for the implants. **I am responsible for all surgical cost after the first year of treatment.** I agree to follow all pre and postoperative instructions.

_____ ***I understand*** that no specific estimate can be made regarding the period of longevity and retention of the implant. If fixtures have to be removed, I should be able to return using a conventional denture or partial denture or possibly have additional fixtures placed in the future. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant(s) may fail.

_____ ***I understand*** that denture or removable prostheses usually cannot be worn during the first 1 to 2 weeks of the healing phase.

_____ ***I understand*** that the practice of dentistry is not an exact science; **no guarantees or assurances** can be made regarding the outcome or the results of treatment or surgery.

_____ ***Short term effects after surgery:*** there may be normal side effects that Dr. _____ will instruct me how to handle at home, such as: swelling, stiffness of the jaw muscles, bruising, occasional oozing of blood for 24 to 48 hours or moderate pain for 24 to 48 hours.

Risks, Benefits and Alternatives

_____ ***Risks, not limited to the following:*** though dental implant surgery has a high rate of success, like all surgery it carries with the possibility of complications not limited to the following:

- Swelling that worsens after 48 hours
- Intense pain that cannot be relieved by prescription medication
- Infection
- Permanent loss or alteration of nerve sensation resulting in numbness or tingling sensation in the lip, tongue, cheek, gum and /or teeth
- Sinus complications
- Excessive or prolonged bleeding
- TMJ (temporomandibular jaw joint) pain or abnormal function of the jaw, jaw fracture
- Adjacent teeth, roots, fillings or bridge work injuries or damage
- Bone loss around the implant
- Implant failure (the bone does not grow around the implant)

_____ ***I understand*** that if any of the above occurs I must immediately contact Dr. _____. If I cannot contact dr. _____ I understand that it is my responsibility to immediately proceed to the nearest hospital emergency room for evaluation and any necessary treatment.

_____ ***Benefits, not limited to the following:*** increased chewing efficiency and improved appearance or speech are the most common benefits.

_____ ***I understand*** that a medical condition can compromise the longevity of an implant.

_____ ***Consequences of implants and prostheses in the mouth:*** I understand that smoking, excessive alcohol consumption, chewing hard foods such as ice or hard candy may result in damage to my implants and can cause them to fail completely.

_____ ***I understand*** that I must keep my implants and prostheses clean by daily maintenance as well as regular checkups and cleanings at Dr. _____'s office.

_____ ***I understand*** that in addition to the risks and complications associated with implants and prosthetics, certain complications may result from the use of anesthetic or sedative. The risks, benefits and alternatives regarding anesthesia have been explained to me and I will disclose any allergies I have and/ or substance or medication I am taking because they affect my response to anesthesia/sedative. If I choose to undergo I.V. or general anesthesia, the anesthesiologist administering the anesthesia will conduct a separate discussion with me and require a separate consent afterwards.

Patient criteria

Almost anybody who is missing teeth can benefit from implant treatment. Those who are experiencing chewing problems and difficulty wearing a removable prosthesis can look to a restoration anchored to an implant as a possible treatment plan. Those that do not have a disease or condition that interferes with proper healing after implant surgery, I.e., uncontrolled diabetes or radiation/ chemotherapy for treating cancer, and who have sufficient bone that is dense enough to secure implants are possible candidates for an implant plan.

_____ ***I understand*** the importance of providing my complete medical history to the dentists who are administering my treatment plan. I have reported any known medications, substances, allergies or prior reactions, abnormal bleeding or any other conditions related to my health.

_____ ***I understand*** that Dr. _____ may decide to cancel the implant surgery once it is underway if I need supplemental bone grafts or other types of grafts to build the ridge to allow placement, gum closure and securing of the implant(s). It may even be discovered once the surgery is underway that I am not a candidate for implant treatment.

I have had my questions answered to my satisfaction. I consent to have Dr. _____ perform the oral surgery to place the necessary implants for my treatment. I authorize and direct this dentist, with his associates, to do whatever they deem necessary and advisable under the circumstances, including not proceeding with the implant procedure once the surgery is underway if I am not a candidate for implant treatment.

Patient's signature

Date

I attest that I have discussed the risks, benefits, consequences and alternatives of implant surgery with _____, who has had the opportunity to ask questions and I believe my patient understands what has been explained.

Dentist's signature

Date

Witness's signature

Date