

XYZ DENTAL CARE

Consent for Dental Implants

Diagnosis and Recommended Treatment: After careful oral examination and study of my dental condition, Dr. Hadian has advised me that my missing tooth/teeth may be replaced with artificial teeth supported by my dental implants. In order to treat this condition, Dr. Hadian has recommended that my treatment include dental implant(s) to be implanted into the jawbone. I understand that this surgical phase is followed by a prosthetic phase where artificial dentures, bridges, or crowns are placed to replace missing teeth.

Please initial on each line indicating that you have read each item.

Surgical Phase of Procedure:

- I understand that sedation may be utilized if scheduled and that a local anesthetic will be administered to me as a part of the treatment. My gum tissue will be opened to expose the bone, implants will be placed, and the gum tissue will be sutured during the healing phase.
- I understand that the healing phase of surgery varies from patient to patient and case to case, but typically last between 2-6 months. I understand that dentures or partial dentures that place pressure on the surgical site are to be avoided for 1-2 weeks following surgery.
- I further understand that if during surgery the clinical situations turn out to be unfavorable for the implant, Dr Hadian will make a professional judgment to manage the situation. This includes canceling the procedure, supplemental bone grafting, and supplemental soft tissue grafting to allow placement, gum closure, and security of the dental implants. These procedures might be done in conjunction or separately from the implant placement.
- I understand that some implants require a second stage surgery to uncover the implant. Overlying tissue will be opened at the appropriate time and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. The artificial crown fabrication may begin after healing of the soft tissue.

Expected Benefits: The purpose of dental implants is to allow me to have more functional artificial teeth, and sometimes improved appearance. The implants provide support, anchorage, and retention for the artificial replacement.

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to implant placement. In such cases, implants may have to be removed and replaced. Because each patient's conditions are unique, long term success may not occur.

- I understand that complications may result from the implant surgery, drugs or anesthetics. These complication include, but are not limited to, post-surgical infection, bleeding , swelling and pain, facial joint injuries or associated muscle spasm, transient but rarely permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in the elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.
- There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a revision procedure if the initial results are not satisfactory. In addition, the success of the dental implant procedures can be affected by medical conditions, dietary and nutritional problems, smoking alcohol consumption, clenching and grinding of teeth, inadequate hygiene, and medications that I may be taking. To my knowledge, I have reported to Dr. Hadian any prior drug reactions, allergies, diseases, symptoms, habits or conditions which might in any way relate to this surgical procedure. I

understand that my diligence in providing the personal daily care recommended by Dr. Hadian and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: I understand that alternatives to dental implant surgery include: no treatment, removable appliances, or fixed bridgework and other procedures depending on the circumstances. However, continued wearing of ill-fitting appliances can result in further damage to the bone and soft tissue of my mouth.

Necessary Follow-up Care and Self-Care: Implants, natural teeth, and appliances must be maintained daily in a clean, hygienic manner. Implants and appliances should be examined by Dr. Hadian periodically. I understand that the failure to follow such recommendations could lead to ill effects which would become sole responsibility. I understand that smoking, or alcohol intake may adversely affect gum healing and may limit the successfulness outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by Dr. Hadian and (2) to see Dr. Hadian for the periodic examinations and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, Dr. Hadian cannot predict the certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my dental implants and surrounding teeth, including the possible loss of certain teeth or implant, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

Patient Consent

I have been fully informed of the nature of the implant surgery, the procedure to be utilized and the benefits of implant surgery, the alternative treatment options, and the necessity for follow-up care and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Hadian. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during the consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Hadian.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT DOCUMENT SURGERY CONSENT FORM (2 PAGES + SIGNATURE PAGE)

Tooth # _____

DATE _____ PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____

DATE _____ WITNESS NAME (PRINT) _____

WITNESS SIGNATURE _____

PARENT/LEGAL GUARDIAN _____