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INFORMED CONSENT FOR DENTAL IMPLANTS

Patient name__________ Date ________

Diagnosis. After careful oral examinations and study of my dental condition, Dr. Davis has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

Recommended Treatment. In order to treat my condition, Dr. Davis has recommended the use of root form dental implants. I understand that the procedure for root form implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.

Surgical phase of procedures. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissues will open to expose the bone. Implants will be placed by tapping or threading them into holes that have been drilled into the jawbone. The implants will have to be snugly fitted and held tightly in place during the healing phase. The gum and soft tissues will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of 4-6 months. I understand the dentures usually cannot be worn during the first one to two weeks of the healing phase. I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants., my doctor will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of crafts to build up the ridge of my jaw and thereby to assist in placement, closure and security of my implants. For implants requiring a second surgical procedure, the overlying tissues 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. Plans and procedures to create an implant prosthetic appliance can then begin .

Prosthetic phase of procedure. This phase is just as important as the surgical phase for the term success of the oral reconstruction. During this phase, an implant prosthetic device will be attached to the implant.

Expected Benefits. The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

Principal Risks and Complications. I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long term success may not occur

I understand the complications may result from the implant surgery, drugs, and anesthetics; These complications include, but are not limited to:

* Post surgical infection
* Bleeding
* Swelling
* Pain
* Facial discoloration
* Transient and, on occasion. PERMANENT numbness of the lip, tongue, teeth, chin or gum
* Tooth sensitivity to hot, cold, sweet or acidic foods.
* Shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between teeth
* Cracking or bruising of the corners of the mouth
* Restricted ability of the corners of the mouth
* Impact on speech
* Allergic reaction
* Injury to teeth
* Bone fractures
* Nasal sinus penetrations
* Delayed healing
* Accidental swallowing or foreign matter

The exact duration of any complications cannot be determined, and they may be irreversible. I understand that the design and structures of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implants. This loss would be the sole responsibility of the person making alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone or at any time thereafter. I also understand that certain complications could lead to a referral to an oral and maxillofacial surgeon for correction, as some complications are beyond the comfort level of Dr. Davis to repair.

Initials___

Alternative to suggested treatment. Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures-depending on the circumstances. Howere, continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissue of the mouth.

Initials___

Necessary follow up care and self care. I understand that it is important for me to continue to see my dentist. Implants, natural teeth, and appliances have to be maintained daily in a clean hygienic manner. Implants and appliances must also be examined periodically and

may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my doctor.

Initials___

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 of reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Initials___

It is my responsibility to contact the dentist and seek attention should any undue circumstances occur postoperatively, and I shall diligently follow any postoperative and postoperative instructions given to me.

Dr Randall Davis training. I understand that Dr Randall Davis is a board certified general dentist with advanced port doctoral training at NYU in surgical placement and prosthetic restoration on dental implants. I also understand that he is not an oral and maxillofacial surgeon or a periodontist. I choose not to be referred to either of these specialities for the procedure.

Initials___

PATIENT CONSENT

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available 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 my doctor. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during consultation and in treatment plan presentation as described in this document. I also consent to the use of an implant system or method if cylindrical conditions are found to be unfavorable for the use of the implant systems that have been described to me. If clinical conditions prevent the placement of implants, I defer to my doctor's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of crafts to build up the ridge of my jaw and thereby to assist in placement., closure, and security of my implant.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Patient signature__________ Date______

Witness signature__________ Date______