

## IMPLANT SURGERY | CONSENT

1. I have been informed and afforded time to fully understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.
2. I have been informed that Dr. \_\_\_\_\_ is a general dentist and a referral to a specialist (oral surgeon, and/or prosthodontist) has been offered.
3. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. These alternatives are \_\_\_\_\_. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
4. I have further been informed of the possible complications and risks involved with surgery, drugs and anesthesia. I understand and accept these possible complications and risks. Such complications can include but are not limited to pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of the veins, injury to teeth present, bone fracture, sinus penetration, delayed healing, allergic reaction to drugs or medication used.
5. I understand that if nothing is done any of the following could occur: bone loss, gum tissue inflammation, infection, and sensitivity, looseness of teeth followed by necessary extraction. Also possible are temporomandibular joint (jaw) problems, headaches, and referred pains to the back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.
6. Dr. Schofield has explained that there is no method to predict accurately the gum and bone healing capability in each patient following the placement of the implant. In general a healing time of 3-6 months is normal. There are instances where implant treatment may not succeed. Alternatives will then be readdressed.
7. It has been explained to me that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome or results of the treatment or the surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.
8. I understand that excessive smoking; alcohol use or blood sugar problems may affect gum and bone healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
9. I agree to the anesthesia, depending on the choice of my doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours, or until fully recovered from the effects of the anesthesia or drugs given for my care.
10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergies or unusual reactions to drugs, insect bites, anesthetics, pollen, dust, blood or body disease, gum or skin reaction, abnormal bleeding or any other conditions related to my health.

11. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of implants dentistry, provided my identity is not revealed.
12. I agree to notify my doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (two to four weeks).
13. I request and authorize medical/dental services for myself, including implants and other surgery. I fully understand the contemplated procedure. I approve any modifications in design, material, or care, if it is felt this is for my best interest. If an unforeseen conditions arise in the course of the treatment which calls for the procedures in addition to or different from that now contemplated, I further authorize and direct Dr. Schofield, to do whatever he deems necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.
14. I recognize that implants are a very successful treatment option. Dr Schofield has offered a guarantee on the implant (not the supporting tooth/teeth) as long as he is in practice if the implant is fully integrated two years after the treatment. I also recognize that this guarantee is void if I do not return to the office for recall examination and scaling every six months, or the appropriate recall interval recommended by Dr. Schofield according to my periodontal condition.
15. In rare instances implant treatment does not succeed including the surgery or prosthetics due to biological factors beyond our control or ability to predict. As such the fee paid is non-refundable. Retreatment will be offered at no charge, however, bone grafting may be required. In other circumstances Dr. Schofield may offer alternative treatment at a reduced fee. The patient is still responsible for any materials cost incurred with the additional treatment. This in no way implies that that we have provided inadequate professional treatment but our desire to see you have the best possible outcome.

**Patient** \_\_\_\_\_

**Date** \_\_\_\_\_

**Witness** \_\_\_\_\_

**Date** \_\_\_\_\_

**Dentist** \_\_\_\_\_

**Date** \_\_\_\_\_