CONSENT FOR
OSSEOINTEGRATED IMPLANT SURGERY

You have the right to be given pertinent information about your proposed implant placement so that you have sufficient information to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is a confirmation that we have discussed the nature of the proposed treatment, the known risks associated with the surgery and the feasible alternate treatments.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR <u>BEFORE</u> SIGNING.

PATIENT: _____ DATE: _____

I hereby authorize Dr. Davis/King, and any other agents, assistants, or employees selected by Dr. Davis/King to treat the condition described as: **<u>OSSEOINTEGRATED IMPLANT SURGERY.</u>**

The procedure necessary to treat the condition has been explained to me and I understand the nature of the procedure. _____

I understand incisions will be made inside my mouth for the purpose of placing one or more root form structures (implant) in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge or denture that later need to be attached to this implant will be made and attached by Dr. Davis/King and that a separate charge will be made for that work involved.

I understand that the implant may need to remain covered by gum tissue for at least four to six months before it can be used and a second surgery may be required to uncover the top of the implant.

No guarantee can be or has been given that the implant(s) will last for a specific time period. 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 may fail.

I have been informed of possible alternative methods of treatment (if any), including: _____ _____. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

 Patient name _____

My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in the specific instance such risks include, but are not limited to the following:

A. Postoperative 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.
D. Postoperative infection that may require additional treatment.
E. Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.
F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened.
G. Injury to the nerve branches in the lower jaw resulting in numbness or tingling of the chin, lips, cheek, gums or tongue on the operated side. This may persist for several weeks, months or, in rare instances, permanently. In some cases the implant may need to be removed.
H. Opening into the sinus (a normal chamber above the upper back teeth) requiring additional treatment.
I. If the sinus is intentionally entered (sinus lift procedure with grafting) there will usually be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
J. The removal of grafted bone from any donor site has its own potential risks and complications which have been explained to me.
K. Fracture of the jaw.
L. Other: _____.

It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed which will necessitate extension of the original procedure from those set forth in above stated risks (A-L). I authorize my doctor and his staff to perform such different procedure(s) as necessary and desirable in the exercise of professional judgment.

I have been made aware that certain medications, drugs, anesthetics and prescriptions which I may be given can cause drowsiness, uncoordination, and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.

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

I certify that I speak, read, and write English and have read and fully understand this consent for surgery and that all blanks were filled in prior to my initialing and signing this form.

 Patient name_____

I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

_____ _____
Patient or legal guardian - signature and print Date

_____ _____
Witness - signature and print Date

_____ _____
Doctor - signature and print Date