# Implant Consent

1. This is my consent for E-Care Dentistry and/or any dentist associated with the group and his/her assistants to perform the treatment identified below.

2. I understand incision(s) will be made inside my mouth for the purpose of placing one or more endosteal metal or coated metal root form structures in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown (cap), denture or bridge. I acknowledge that the Doctor has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant by a restorative dentist not the oral surgeon and the cost for that work is not included in the charge for this procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant must remain covered under the gum tissue for at least three months before it can be used and that a second surgical procedure is required to uncover the top of the implant. I also understand that there will be no refund of the fees in the event of failure. It has also been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed, and completed on schedule. If this schedule is not carried out, the implant may fail.

3. I have been informed of the alternatives to the use of an osseointegrated implant, including no treatment at all or construction of a fixed or removable partial denture. The advantages and disadvantages of each of the above procedures have been explained to me and I choose to proceed with the insertion of the osseointegrated implant.

4. I also authorize and direct the Doctor and his assistants to provide such additional services as he/she may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary laboratory, radiological (x- ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion or by other medically accepted routes of administration; and the removal of bone, tissue and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices. If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition or different from that now contemplated and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed and necessary and advisable under the circumstances.

5. I understand that there are risks associated with this procedure and these have been explained to me. They may include, but not limited to, swelling; damage to and possible loss of other teeth, fillings or other dental work; infection or abscess; pain; bleeding ; poor healing; loss of bone; fracture of the jaw; stretching of the corners of the mouth with resulting cracking and bruising.

6. *****Lower jaw implants***** In addition with the placement of lower implants there may also be possible injury to nerves near the treatment site which may cause pain, burning, numbness or tingling of the lips; chin, face, mouth, teeth and tongue (which is usually temporary but may be permanent) and possible loss of or damage to the ability to taste.

7. Although a good cosmetic result is hoped for, it cannot be guaranteed. I also understand that any of these treatment complications may necessitate additional medical, dental, or surgical recuperation at home or even in the hospital. I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of the implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period.

8. Finally, I understand that the success of the implant requires maintenance and care on the part of the patient and the Doctor. I understand that failure to care for the implant in the proper manner can result in its loss. I have been advised that smoking greatly increases the failure rate of implants and that if I continue to smoke or start to smoke, I will be at increased risk of losing one or all of the implants. I also understand that failure to keep regular recall appointments with the Doctor and the restorative dentist for examinations and evaluation of the implant can also result in loss of the implant. I further understand that there may be charges for these visits after one year from the time the implant was placed.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE.