

DR. RICKY SEE & ASSOCIATES

IMPLANT PATIENT INFORMATION AND CONSENT

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant in the bone.
2. My dentist has carefully examined my mouth. Alternatives to this treatment including denture and bridge have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with implant and bone graft surgeries, drugs, and anesthesia. Such complications include pain, swelling, bruising, bleeding, infection and discoloration of teeth and/or facial soft tissue. 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 a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
5. My dentist has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
6. It has been explained that in some instances implants and/or bone grafts are rejected. Rejected implants might have to be removed. Additional bone graft or soft tissue enhancement surgeries might be necessary in case of bone graft rejection or excessive resorption. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.
7. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my dentist's home care instructions. I agree to report to my dentist for regular examinations as instructed.
8. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
10. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I agree to the type of anesthesia, depending on the choice of my dentist. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

CONSENT

Signature of Doctor

Signature of Patient / Guardian

Witness

Date