Holton Dental

PATIENT INFORMED CONSENT FOR IMPLANT

Patient name: _____ **DOB**: _____

Surgical Procedures: _____

This authorization and informed consent is given of my own free will after my dentist has explained to me the foreseeable dental and medical risks involved, as discussed below.

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 under the gum or in the bone.

2. My dentist has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the missing teeth.

3 I understand that if nothing is done, any of the following may occur: loss of bone in my jaw, temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles and tired muscles when chewing.

4. I have further been informed of the possible risk and complications involved with surgery, drugs, and anesthesia. Such complications as pain, swelling, infection and bruising, 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 injury to teeth, bone fractures, sinus penetration, delayed healing, or allergic reactions to drugs or medications used.

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 fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science and that there can be no guarantees or assurances as to the outcome or results of the treatment or surgery.

7. I understand that smoking, alcohol or systemic medical conditions may affect gum healing and may limit the success of the implant. I agree to follow my doctors home care instructions.

8. I agree to the type of anesthesia, depending on the choice of my dentist. If sedative drugs and narcotics are used, I agree not to operate a motor vehicle or hazardous device for at least 4 hours or more until I fully recover from the effects of anesthesia or drugs given for my care.

9. 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 blood diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.

10. I understand that once my treatment is completed at Holton Dental, I must return for regular examinations and cleanings and have my implants professionally maintained. These maintenance visits will need to be a minimum of two times per year and possibly as often as four times a year depending on my specific periodontal health and that the failure to do so could result in accumulation of plaque and tarter on the implant, gum disease around the implant(s), bleeding, infection of the implant(s) and/or bone loss. I understand that part or all of the implant(s) could become exposed, the implant(s) could loosen, become uncomfortable or could even require removal along with any prosthesis that the implant(s) may have supported if I don't undergo periodic maintenance appointments. If any of the above were to happen to the implant(s) placed at Holton Dental, you may experience swelling, infection, pain and may need treatment by a dentist or specialist outside of Holton Dental resulting in fees owed to the doctor or specialist or experience a loss of chewing ability or change in the appearance of the mouth or facial appearance for which Holton Dental would not be liable.

11. I understand that if no treatment is performed, any of the following may occur: loss of bone in my jaw, temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

12. 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 judgement of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Please check the boxes below before signing to acknowledge your consent

- ☐ I consent to photography, filming, recording, radiographs and/or digital imaging of the procedures to be performed for the purpose of dental education and the advancement of dentistry.
- ☐ I certify that I have read and fully understand the above authorization and informed consent and the information referred to the above and that all of my questions have been answered.

Signature: _____ **Date**: _____