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Informed Consent for Implant Surgery and Reconstruction

I have been informed during my consultation about the nature of my proposed implant treatment including the nature of implants, implant surgery, risks of treatment, restorative phase of treatment, requirements and limitations of follow-up care, and about alternatives to this treatment, including no treatment.

1. IMPLANT SUCCESS: I understand that for implants to be successful they normally must bond directly to bone (called osseointegration). It has been explained to me that implants are not always successful, and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implant(s) or will be removable by me, unless the restoration is already planned to be removable.

2. TREATMENT: I understand that the initial surgical procedure involves making an incision in the soft tissue and exposing the underlying bone. A bone graft or other surgical procedure may be required for the implant placement. Holes are drilled into the bone and the implant(s) will be placed into these holes. The gums are then stitched closed and the area allowed to heal for a variable period of time (2-6 months, or more). I understand that I may have to avoid wearing any type of restoration/appliance over the implant site(s) for a period of time after the surgery.

   After the healing period, a second surgical procedure may be performed to expose the implant(s) and attach extensions to the implant(s) that will eventually support the restoration(s). After this second surgery; the prosthodontic (reconstruction) phase of my treatment will take place and will involve multiple appointments. This second surgery will not apply for certain types of implants. The doctor will notify me as to the need, if any, of this second surgery.

   The estimated treatment time could be increased if there is a need for a bone graft or other surgical procedure. Treatment time could also be extended if there are surgical complications.

3. ALTERNATIVES TO IMPLANTS: I have considered the following alternatives to implant treatment.
   -No treatment
   -Construction of conventional complete or partial denture(s) or maxillofacial prosthesis.
   -Tooth replacements with conventional bridgework supported by my remaining natural teeth (if possible).

4. RISKS OF IMPLANT TREATMENT: I have been informed and I understand that surgical risks include, but are not limited to: (1) post operative swelling and limited mouth opening that may last for several days, (2) infection, (3) bleeding, (4) adverse drug reaction, (5) discomfort, (6) bruising, (7) injury to adjacent teeth, (8) perforation of the sinus or floor of nose, (9) bone fracture, (10) jaw joint surgery, (11) loss of one or more implants, and (12) damage (transient or permanent) to the nerve that gives feeling to the lower lip that could result in numbness, tingling, or other sensation in the lower lip.

I understand that prosthodontic risks include, but are not limited to: (1) failure of an implant to osseointegrate (may be immediate or delayed), (2) fracture of the implant and/or implant components, (3) wear of the restoration requiring remake, (4) compromised esthetic or functional outcome as a result of implant loss or less than ideal angulation or position of the implant(s), (5) inability to restore or use an implant(s) due to improper angulation or position or of the implant(s), and (6) inability to restore or use an implant(s) due to damage to the head of the implant(s) such that it will not allow for proper fit of the restorative components.

I understand that failing implants would require surgical removal, and may require additional prosthodontic procedures or the subsequent placement of additional implant(s).

5. NO GUARANTEE: No guarantee of any kind has been made to me that the proposed implant treatment will be completely successful or that the final restorations(s) will be totally successful from a functional or esthetic (appearance) standpoint. I understand that no medical or dental procedure is totally predictable and that this includes treatment with osseointegrated implants. I understand that because of known or unforeseen factors, further surgical, orthodontic, and/or prosthetic procedures beyond those described to me might be necessary.

If an implant fixture fails to osseointegrate, or if it requires removal for any reason for a period of one year from the date of its insertion, a limited warranty will apply. This limited warranty does not imply or admit liability in any way by the surgeon or the surgical assistant(s). Depending upon my approval, this limited warranty allows the surgeon to:

1) remove the implant fixture and refund to me 50% of the actual fee that I paid for this surgery. There may be an additional fee to remove the implant. I understand that my jaw bone may be permanently altered by the removal of the implant. I understand that this limited warranty will not cover this alteration or defect, since this is a normal outcome of implant removal. If I choose to pursue a bone regeneration graft for this defect, it will require a separate procedure and fee and will not be covered by this limited warranty.

<u>OR</u>

2) remove and replace the implant fixture for no additional fee. I will not receive any refund for this option. I understand that that if this second fixture placement surgery fails, that I will have no further recourse under this limited warranty. Also, if additional surgical procedures are deemed necessary, they will not be covered by this limited warranty and will require a separate procedure and fee.

I understand that this limited warranty is offered only as a goodwill gesture to the surgeon's patients and in no way implies or offers any guarantee that this procedure or future procedures will be successful to my satisfaction. In order for this limited warranty to remain in effect, I agree to comply fully with the surgeon's prescriptions and directions. This includes any implant maintenance visits which are a separate procedure and fee and are not covered by this limited warranty.

6. FOLLOW-UP CARE: I understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene and maintenance procedures as directed by the doctor or his staff, and that I diligently continue follow-up and recall appointments.

The follow-up care for which I am responsible could include repair or replacement of the implant and/or restoration. This repair or replacement may be needed several times over the years of service of the implant and/or restoration. I understand that implant placement and/or restoration and non-surgical follow-up care of the implant may cost considerably more than a

routine restoration (conventional crowns, bridges, dentures, partial dentures, maxillofacial prostheses not involving the use of dental implants) and that the associated expenses are totally my responsibility.

7. Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

8. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable.

9. I have had an opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby give my consent to the placement of implants and the associated prosthetic procedures for restoring the implants by Dr. _____ and Dr. Joseph Kim.

_____
Patient Signature and Date

_____
Witness Signature and Date

_____
Doctor Signature and Date