Art of Periodontics
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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 it and the feasible alternate treatments.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE DOCTOR BEFORE INITIALIZING.

Patient Name: ____ Date: ___________________

1. I hereby authorize MahnazZandi D.D.S., M.S. and any other agents, assistants, or employees selected by this office Art of Periodontics to treat the condition described as surgical placement of Dental Implant (s). _______

2. The procedure necessary to treat the condition has been explained to me, and I understand the nature of the procedure to be the placement of dental implant (s). _______

3. 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 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 incision (s) and the type of implant to be used. I understand that a crown, bridge or denture that will later be attached to, these implant (s) will be made and attached by my restorative dentist (________________) and that a separate charge will be made for that work. On occasions bone grafting procedure may be necessary at the time of implant (s) treatment to increase bone volume and thickness around implant (s). To do Autogenous (own bone), Allograft (human cadaver bone), Xenograft (animal, usually bovine bone) and/or Synthetic bone material, and/or membranes (bandage for bone graft) may be used. If non restorable membrane is used, a second surgery is necessary to remove the membrane. All bone substitute materials and membranes are tested and screened by their manufactures for safety
use. _______

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

5. No guarantee can be or has been given that the implant (s) will last a specific time period. The implant (s) may fail to integrate to the jaw. Failed implant (s) can be replaced after bone healing. On occasions additional bone augmentation procedure may be necessary to replace a failed implant. It has also been explained to me that once implant (s) are inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant (s) may fail. _______

6. I have been informed of possible alternative methods of treatmentincluding fixed bridges and removable dentures. 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. _______

7. The doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this 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 if present. _______
   D. Postoperative infection that may require additional treatment including removal of the implant. _______
   E. Stretching of the corners of the mouth that may cause cracking and bruising, may heal slowly. _______
   F. Restricted mouth stress on the jaw joints (TMJ). Pre-existing TMJ may be worsened. _______

G. Injury to the nerve branches in the jaw resulting in numbness or tingling of the chin, lips, cheek, gums, teeth, lower eyelid, side of the nose, 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 in 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: ____

8. It has been explained to me that during the course of this procedure, unforeseen condition may be revealed which will necessitate extension of the original procedure or a different from those set forth in **Paragraph 2**above. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such different procedure (s) as necessary and desirable in the exercise of professional judgment. _______

9. I consent to the administration of local anesthesia in connection with the procedure referred to above. On occasions, local anesthesia administration may cause soreness, muscle spasm and limited jaw opening for several days or weeks due to intramuscular injection. If intravenous anesthesia is used, there may be soreness at the injection site or along the vein, as well as some bruising around the injection site. In rare cases, the vein irritation may cause restricted mobility of the arm or hand and may require additional treatment. _______

10. I have been made aware that certain medications, drugs, anesthetics and prescription which I may be given can cause drowsiness, incoordination, and lack of awareness which as 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 the 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. _______

11. If intravenous anesthesia is used, I understand that I am not to have **anything (or have not had anything)** by mouth for at least six hours before my surgery. _______

TO DO OTHERWISE MAY BE LIFE-THREATENING!

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

13. 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 initializing and signing this form. _______

14. 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 any reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

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

____ ________________
Patient's signature or legal guardian's Date

____ ________________
Patient's signature or legal guardian's Date

____ ________________
Doctor's signature Date