Dental Implant Consent Form

Caleb S. Beam, D.D.S.

Patient Name _____

Tooth Number(s)_____ Date _____

While we believe that patients have a right to be informed about any treatment they receive, the law requires extensive disclosure of the risks of surgery and local anesthesia, many of which are unlikely to occur. Please feel free to ask the doctor about the risks or complications disclosed herein that may apply to you based on your clinical experience and that of other dental professionals who place implants. **Please initial next to each of the following:**

_____ 1. After careful examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth amy be replaced with artificial teeth supported by an implant.

_____ 2. The procedure I choose to treat this condition is understood by me to be the placement of a root form implant(s). Additional treatment procedures may include a bone graft. I understand the purpose of this procedure is to allow me to have more functional, artificial teeth by the implants providing support, anchorage, and retention for these teeth.

_____ 3. I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function, and that an alternative option is to not undergo surgery and do nothing. I have also been advised that other alternative treatments exist, but I choose to undergo the placement of root form implant(s).

_____ 4. I understand that my gum tissues will be surgically opened to expose the bone and that implants will be placed immediately. I understand that the implants placed will be fully integrated into the bone in about 3-9 months, depending on my personal healing ability.

_____ 5. I have had the opportunity to discuss with the doctor the planned procedure, implant placement, and my post-operative responsibilities. I understand following the procedure and during the healing process, I *should not* smoke, drink heavily, or use any drugs not prescribed by my doctor. I understand I *should* take any prescribed antibiotics and use pain medication, as needed. If I experience an unusual amount of pain, I should contact the doctor's office immediately, as it could signify a problem.

_____ 6. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful. I also understand, due to individual patient differences and the imperfections of the art and science of surgery, there are risks of failure or necessity of additional treatment, despite appropriate care. I have been advised of long term success rates of root form implants; however, I understand such disclosure does not imply that my personal experience will be the same. There will be no refund of fees in the event of complications requiring additional surgery. Should implant removal be required due to complications, the implant will be removed at no additional cost. However, should I elect to have another doctor remove my implant, I am solely responsible for all costs and fees associated in doing so.

Risks

The doctor will give his best professional care toward accomplishment of the desired results.

The substantial and frequent risks of the proposed procedure are as follows:

- Restricted mouth opening
- Gum shrinkage around the extracted or missing tooth/teeth
- Clicking or pain of the TMJ or jaw joints
- Tooth sensitivity of the surrounding teeth to hot or cold for days and even up to months following surgery
- Loose teeth surrounding the extraction or missing tooth/teeth
- Food getting trapped between teeth requiring removal and extra care
- Unaesthetic exposure of crown margins in the area of surgery

The more uncommon risks of the proposed procedure are as follows:

- Interference with speech sounds
- Permanent nerve injury or nerve paralysis
- Added surgical procedure to restore nerve function

The doctor and assistant have explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options available, including not having anything done. Understanding this form, I elect to proceed with the placement of root form implant(s).

I authorize Caleb S. Beam, D.D.S. to perform the procedure listed in the title above.

_____ _____

Patient or Representative Signature Date

_____ _____

Doctors Signature Date