kenner dental group
COSMETIC AND RESTORATIVE DENTISTRY

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Implant Consent

My doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant (s) either on, in, or through the bone.

I understand that the risk associated with the use of a dental implant is the failure and loss of the implant that could further reduce the minimal amount of existing bone that I now have, requiring more extensive bone grafting and other surgical procedures at some future time. I promise to, and accept responsibility for failing to, return to this office for examinations and any recommended treatment, at least every 4-6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold my dentist harmless if my implant(s) fail as a result of not maintaining an ongoing examination and preventive maintenance routine as directed by my dentist, or by continuing to smoke, or begin smoking during and after implant treatment. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post surgical dental procedures. I am further aware that there is a risk that the implant placement may fail, through no one's fault, which then might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.

I understand that implant success is dependent upon a number of variables including, but not limited to: individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.

I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia and related drugs including, but not limited to: failure of the implant (s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures. I understand that any of these complications could occur even when all dental procedures are properly performed.

I have been advised that smoking and alcohol consumption may affect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my dentist or hygienist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will more than likely contribute to the failure of the implants.

Initial_____

I have also been advised that there is a minimal risk that the implant may break, which may require additional procedures to repair or replace the broken implant.

I authorize my dentist to perform dental services for me, including implants and other related surgery such as bone augmentation.

I approve any reasonable modifications in design, materials, or surgical procedures, if my dentist, in his/her professional judgment, decides it is in my best interest to do so.

To my knowledge, I have given an accurate report of my health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, dust; blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I understand that certain mental and/or emotional disorders may increase the risk of failure or contraindicate implant therapy and have therefore expressly circled either **YES** or **NO** to indicate whether or not I have had any past treatment or therapy of any kind or type for any mental or emotional condition.

I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records that identify me will be used without my express written consent.

I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.

I agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences, which result from not following my dentist's advice.

I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION AND CONSENT TO IMPLANT PLACEMENT, AND ALL MY QUESTIONS, IF ANY, HAVE BEEN FULLY ANSWERED. I UNDERSTAND AND AGREE THAT MY INITIAL ON EACH PAGE, ALONG WITH MY SIGNATURE BELOW, ESTABLISHES THAT I HAVE GIVEN MY INFORMED CONSENT TO PROCEED WITH TREATMENT.

Dentist Signature _____

Patient Signature _____

Witness Signature _____

Patient Name _____

Date_____

Initial_____