

Dental Implant Consent Form
Tuscany Dental Centre ~ Dr Cam Brauer &/ Dr Juhee Ko & / Dr Irina Baci

Patient Name: _____ Date: _____

My Planned procedure will involve placement of (#) _____ implant(s).

*Please initial each paragraph after reading. If you have any questions, please ask your doctor for clarification.

_____ I understand that dental implants are placed in stages. The implant will be placed in the bone and will osseointegrate for 3 months prior to a crown being placed, and up to 6 months if grafting material has been placed.

_____ I understand that there will be an incision made inside my mouth for the purpose of placing one or more dental implants in my jaw to serve as anchors to replace a missing tooth or teeth, upon which an abutment and a crown, bridge, or denture will be secured. I acknowledge that the procedure has been explained to my full understanding, including the number and location of implants and the type of implant that will be used. I understand that at a minimum there will be a charge for the implant, the crown, bridge or denture.

_____ I understand that in certain circumstances, the surgery may involve additional materials and procedures (grafting with bone or artificial bone substitutes, use of healing membranes and associated fixation devices). The need for those procedures may not be apparent until after the surgery has begun. I understand that additional fees may be charged without financial arrangements being made if additional procedures are deemed to be necessary.

_____ Alternative treatment methods such as doing nothing, bridges, or dentures has been explained to me.

_____ I Understand the risks and complications of dental implant surgery include, but are not limited to:

*Post – operative discomfort and swelling that may require several days of at-home recuperation.

*Prolonged or heavy bleeding that may require additional treatment.

* Damage to adjacent teeth or roots of adjacent teeth

*Post-operative infection that may require additional treatment.

*Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly

* Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joint.

*Numbness, tingling, or pain in the chin, lips, cheeks, gums, tongue including possible loss of taste sensation or teeth on the operated side(s). These symptoms may persist for several weeks or months, and in some cases may be permanent.

* Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.

* Bone loss around the implants

*Implant or prosthesis failure. Rarely, the implant or parts of the structure holding the replacement tooth, or the replacement tooth itself, may fail due to chewing stresses.

*Rejection of the implant by natural body defenses. (If the implant is lost, it is usually possible to replace it in a later surgery after the bony defect has healed or been bone grafted to achieve adequate bone volume for another implant procedure.

_____ No guarantee can be or has been given that the implant(s) will last for a specific time period. I acknowledge that there is the risk for failure, relapse, selective re-treatment, or worsening of my present condition, despite efforts at optimal care.

_____ If you are a smoker there is no guarantee that the implant will integrate.

_____ Maintenance of the implant site as well as continuing hygiene care /interval will be dependent upon the hygienist's recommendation.

My signature below signifies that all questions regarding this consent have been answered to my satisfaction, and I fully understand the risks involved with the proposed procedures and anesthetic. I certify that I read, and understand English. I hereby give my consent for the planned surgery.

Signature of Patient or Guardian _____

Date _____

Signature of Dentist _____

Date: _____