

Implant Treatment Consent Form

What you are being asked to sign is a confirmation that we have discussed the nature and purpose of implant treatment, the known risks associated with implant treatment, and the feasible treatment alternatives, and that you have been given the opportunity to ask questions and that all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

1. I have been informed and understand the purpose and the nature of the implant surgery procedure. I understand the procedure that is necessary to accomplish the placement of the implant in the bone. I also understand that upon entering the surgical site, it may be determined that the implant placement is not possible.

2. I understand that Dr. _____ has carefully examined my mouth. Alternatives to implant treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replacement restoration for my missing teeth.

3. I have been informed of the possible risks and complications involved with implant prosthetics that include but are not limited to the following: implant fracture, screw loosening or fracture, acrylic or porcelain fracture or cement failure. I have also been informed that the survival rate of the implant prosthetic is approximately 89% after 10 years in function.

4. The dentist has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following tooth extraction or the placement of the implant. If there is inadequate bone or gum tissue, there may be a need for additional treatment. This is in the form of grafting procedures. It has been explained to me that sometimes implants fail and need to be removed.

5. I understand that excessive smoking may affect gum healing and may limit the success of the implant. I agree to follow the home care instructions provided to me. I agree to report to Dr. _____ for regular examinations as indicated in order to maintain our warranty policy.

6. I understand that an x-ray will be taken before, during and after treatment. A number of x-rays are required during the course of the implant therapy and that every situation is different.

7. I understand that the implants used have full compliance under the regulations of Health and Welfare Canada or have been approved by Health and Welfare Canada for clinical trials. I give permission to Dr. _____ to use whatever implants he feels are appropriate for my treatment.

8. I understand that I may not have sufficient bone for the placement of implants. I consent to the use of grafting materials in an attempt to create more bone. These materials include bone products derived from humans, animals or are synthetic.

9. To my knowledge, I have given an accurate report of my physical and mental health history. I have

reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, latex, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.

10. I consent to photography, study models and X-rays of the procedure to be performed for use in teaching dentistry, education of patients, and other graphic purposes. I understand that my name will not be identified in these situations.

11. I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove the plaque off all surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail.

I have been fully informed of the nature of implants and implant surgery, therapeutic risks and complications and prosthodontic alternatives to oral implants and hereby consent to treatment.

I authorize Dr. _____ perform the procedure. I know that I am free to withdraw from treatment at any time.

Patient/Guardian Name (Please Print)	Patient/Guardian Signature	Date
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Witness Signature	Dentist Signature	Date
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