

PARK FAMILY DENTAL
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CONSENT FOR ROOT FORM DENTAL IMPLANTS

DIAGNOSIS- After a careful examination and study of my condition, my doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

RECOMMENDED TREATMENT- In order to treat my condition, my doctor has recommended the use of root form dental implants. This procedure has a surgical phase, which may consist of multiple surgeries, followed by a prosthodontic or restorative phase. I understand that from start to finish this treatment may take anywhere from four to eighteen months.

SURGICAL PHASE OF THE PROCEDURE- I understand that a local anesthetic will be administered to me as part of treatment. My gum will be opened to expose the bone. Implants will be placed into my into the holes that have been drilled into my jawbone. The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed for a period of three to twelve months. I understand that dentures usually cannot be worn during the first two weeks of healing.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my doctor will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure and security of my implant.

For implant requiring a second surgical procedure, the overlying tissues will be reflected and the stability of the implant will be verified. If the implant appears satisfactory, an attachment which will protrude through the gum tissue will be placed into the implant. Procedures to create the implant tooth/teeth replacement can then begin.

PROSTHODONTIC PHASE OF PROCEDURE- This phase is just as important as the surgical phase for the long term success of the oral reconstruction. During this phase , an implant prosthodontic device will be attached to the implant. This procedure should be performed by a person trained in the prosthodontic protocol for the root form implant system.

EXPECTED BENEFITS- The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage and retention for

these teeth.

PRINCIPAL RISKS AND COMPLICATIONS- I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long term success may not occur.

I understand that complications may result from the implant surgery or the drugs and/ or the anesthetics used. These complications include, but are not limited to : post surgical infection, bleeding, swelling, pain, facial discoloration transient, but on occasion permanent numbness of the lip tongue teeth chin or gums, jaw joint injuries or associated muscle spasms, transient, but on occasion, permanent increased tooth looseness and/ or tooth sensibility to hot, cold, sweet or acidic foods, shrinkage of the gums upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to teeth, bone fractures, nasal sinus penetrations, delayed healing and/ or accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

I understand that the design and structure of the tooth/teeth replacement can be a substantial factor in the success or failure of the implants. I further understand that alterations made on the artificial appliance or the implant can lead to the loss of the implant or appliance. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

ALTERNATIVES TO SUGGESTED TREATMENT- Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures—depending on the circumstances. However continued wearing of ill fitting and loose removable appliances can result in further damage to the bone and soft tissues of the mouth.

NECESSARY FOLLOW UP CARE AND SELF CARE- I understand that it is important for me to see my doctor. Implants, natural teeth and prostheses have to be maintained daily in a clean, hygienic manner. Implants and prostheses must also be examined periodically and may need to be adjusted, I understand that it is important for me to abide by the specific prescriptions and instructions given to me by my treating dentists.

NO WARRANTY OR GUARANTEE- I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, success cannot be predicted with certainty. There exists the risk of failure, relapse, additional treatment, or worsening of my existing condition, including the possible loss of certain teeth, despite the best care.

PUBLICATION OF RECORDS- 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 reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

PATIENT CONSENT

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity of follow up care and self care. I have had an opportunity to ask any questions I may have in the connection with the treatment and to discuss my concerns. After thorough deliberation, I hereby consent to the performance of dental implant surgery.

I also consent to use an alternative implant system of method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my doctors judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts or membranes to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

WITNESS' SIGNATURE

DATE

DOCTORS' SIGNATURE

DATE