Consent for Endosteal Osteointegrated Implants

I hereby authorize Dr. David Dodd to perform surgery upon me (or upon the person identified below as the patient, for whom I am empowered to consent), to insert an implant/or implants in my upper and/or lower jaw.

I understand an incision or incisions will be made inside my mouth for the purpose of placing one or more endosteal metal root form structures in my jaw(s) to serve as an anchor or anchor(s) for a missing tooth or teeth or to stabilize a crown, denture or bridge. I acknowledge that Dr. Dodd has explained the procedure, including the number and location of the incisions to be made, in detail. I understand the crown (cap), denture, or bridge will later be attached to this/these implants by Dr._____ and the cost for that work is not included in the charge for this procedure. I also understand that this implant should last for many years, but no guarantee that it will last for any specific time can be or has been given. I understand in three to four months the abutment will be attached and the fee for that abutment is included in the cost of the implant. I also understand there will be no refunds in the event of a failure. It has been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.
I have been informed of the alternatives to use of an osteointegrated implant, including no treatment at all, construction of a new ridge of my upper or lower jaw by means of vestibuloplasty (plastic surgery on my gums), skin and bone grafting or with synthetic materials, and implantation of another type of device. The advantages and disadvantages of each type of the above procedures have been explained to me and I choose to proceed with insertion of the osteointegrated implant(s).

I also authorize and direct Dr. Dodd to provide such additional services as he may deem necessary, including, but not limited to, the administration of anesthetic agents, the performance of necessary laboratory, radiologicial (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion, or by the medically accepted route of administration; and the removal of bone, tissue and fluids for diagnostic and therapeutic purposes and retention or disposal of same in accordance with the usual practices. If any unforeseen condition arises in the course of treatment which call for the performance of procedures in addition to or different from that now contemplated and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed necessary and advisable under the circumstances with the exception of _____ (if NONE put “none”). Prior to performing such additional or different procedures, however, I desire that they be discussed with _____ (relationship, _____), whom I hereby authorize and designate to give consent to treatment on my behalf whenever possible.

I understand that there are risks associated with this procedure and these have been explained to me. They may include, but are not limited to swelling, damage to and

possible loss of other teeth, fillings and other dental work; infection or abscess; pain, significant bleeding which may be heavy or prolonged; sinus or nasal problems or infection; poor healing; loss of bone; fracture of jaw; injury to nerves near the treatment site which may cause pain, numbness or tingling of the lips, chin, face, mouth, teeth and tongue (which is usually temporary but may be permanent); loss or damage to the ability to taste; stretching of the corners of the mouth and resultant cracking bruising; accidental opening and infection of the normal sinus cavity located above the upper teeth. Although a good cosmetic result is hoped, it cannot be guaranteed. I also understand that any of these treatment complications may necessitate additional medical, dental, or surgical recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during procedure which may prevent placement of the implant, and that rejection of this implant possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period and that a charge will be made this procedure.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND ALSO STATE I READ AND WRITE ENGLISH.

_____

PATIENT, PARENT OR GUARDIAN DATE

_____

SURGEON DATE