PATIENT NAME: _____ DATE: _____

CONSENT FOR TWO-STAGE ENDOSTEAL OSSEOINTERGRATED IMPLANTS

_____ 1) I hereby authorize _____- and any other agents or employees of and such assistants as may be selected by any of them, to perform surgery upon me (or) upon the person identified below as the patient, for who I am empowered to consent), to insert or place a two-stage endosteal osseointergrated implant in my upper and/or lower jaw.

PROCEDURE:

_____

_____

_____

_____ 2) I understand that incision(s) 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 anchor(s) for a missing tooth or teeth or to stabilize a crown (cap), denture or bridge. I acknowledge that _____ has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant by Dr._____ and that the cost for that work is not included in the charge for this procedure. I also understand that this implant will last for many years, but no guarantee that it will last a specific period can be or have been given. I have been informed that the implant must remain covered under gum tissue for at least four months for the lower jaw and six months for the upper jaw before it can be used and that a second surgical procedure is required to uncover the top of the implant. I also understand that there will be no refund of the fees in the event of failure. If the failure is surgical in nature, a replacement implant will be inserted at no charge. It has been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.

_____ 3) I have been informed and understand that the placement of oral implants involve both a mechanical (use of screws or cement to hold or fix the implant components) and biological (osseointergration or fusion to bone) process. I further understand that it is impossible to expect a 100% success rate and therefore there is not a 100% guarantee on the implant(s).

_____ 4) I have been informed of the alternatives to the use of an osseointergrated implant, including no treatment at all: construction of a new ridge of my upper and/or lower jaw by means of a vestibuloplasty (plastic surgery on the gums), skin and bone grafting with synthetic materials and implantation of another type of device. The advantages and disadvantages of each of the above-mentioned procedures have been explained to me and I choose to proceed forward with insertion of the osseointergrated implant(s).

_____ 5) I also authorize and direct _____ and his associates or assistants to provide such additional services as he/she or they deem reasonable and necessary including, but not limited to, the administration of anesthetic agents; the performance of necessary lab work, radiographs and other diagnostic procedures; the removal of bone, tissue and disposal of same in accordance with usual practices. If any unforeseen condition arises in the course of my treatment which calls for the performance of procedures in addition to or different from the 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.

_____ 6) I understand that there are risks associated with this procedure and that these have been explained to me. They may include, but are not limited to: swelling, damage to and possible loss of other teeth, fillings or other dental work, infection, poor healing, loss of bone, fracture of the 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 of or damage to the ability to taste, stretching of the corner of the mouth with resulting cracking and bruising, accidental opening and infection of the normal sinus cavity located above the upper teeth. Although a good cosmetic result is hoped for, 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. I have also been informed that this treatment may not be successful, that problems may arise during the procedure, which may prevent placement of the implant, and that rejection of this implant is 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 may be made for this procedure.

_____ 7) I have been informed and understand that the use of tobacco products (cigarettes, cigars, and pipes, chewing tobacco) may lower the overall success rate of dental implants and/or cause failure (loss) of the implant(s) placed.

_____ 8) I understand and agree to follow-up care as required by _____ or another qualified oral surgeon. Failure to follow up may lead to possible failure (loss) of the implant(s). Dr_____ will not be responsible for implant loss secondary to failure to follow-up in our office.

_____9) In case of implant failure secondary to first stage implant surgery (failure to osseointergrate), my choices/options would be:

a) Re-implant the area after an adequate healing time at no charge except for the cost of general anesthesia (if applicable)
b) Bone grafting charges are not reimbursable.

_____ 10) _____ will not be held responsible for implant loss secondary to restorative failures (work preformed by your restorative dentist i.e. Crowns, bars, clip-bar dentures).

NOTE: The cost of general anesthesia, if applicable, is not included in any reimbursement agreement. With regards to reimplantation, if general anesthesia is used, I will incur an additional charge for the general anesthesia, but not for the implant.

BONE GRAFTING

I have been informed by _____ that during the course of implant placement, it may become necessary to place a bone substitute in order to obtain primary stabilization of the implant(s) and/or to correct bony defects around where the implant(s) are being placed.

In addition to the risks of the primary surgical procedure which has been explained to me, I understand that bone grafting itself involves specific risks. The doctor has explained to me that such risks include, but are not limited to, the following:

a) Rejection of bone particles from the grafted area for some time after surgery.
b) Rejection of the donated or artificial graft material.
c) The remote chance of viral or bacterial disease transmission from processed bone even though no documented cases of transmission has been reported.

I understand that in my grafting procedure, the use of _____.
Bone is expected to be taken from _____ plus _____.

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 EXPLAINATION REFERRED TO AND MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTATION OR COMPLETION WERE FILLED IN PROPERLY. I ALSO STATE THAT I CAN READ AND WRITE ENGLISH.

PATIENT DATE

WITNESS DATE

SURGEON DATE