CHAD KASPEROWSKI
DMD

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DMD

Informed Consent Form for Implant Treatment

I have been informed during my consultation about the nature of my proposed implant treatment including the nature of implants, implant surgery, risks of treatment, restorative phase of treatment, requirements and limitations of follow-up care, and about alternatives to this treatment, including no treatment.

1. Implant success: I understand that for implants to be successful they normally must bond directly to bone (called osseointegration). It has been explained to me that implants are not always successful, and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implant(s) or be removable by me.
2. Treatment: I understand that the initial surgical procedure involves making an incision in the soft tissue and exposing the underlying bone. Holes are drilled into the bone and the implant(s) will be placed into these holes. The gums are then stitched closed and the area is allowed to heal for a variable period of time (3-6 months, or more). I understand that I may have to avoid wearing any type or restoration/appliance over the implant site(s) for a period of time after the surgery. After the healing period, a second surgical procedure is performed to expose the implant(s) and attach extensions to the implant(s) that will eventually support the restoration(s). After this second surgery, the prosthetic phase of my treatment will take place and will involve multiple appointments.
3. Alternatives to Implants: I have considered the following alternatives to implant treatment:
    a. No treatment
    b. Construction of conventional complete or partial denture(s) or maxillofacial prosthesis.
    c. Tooth replacements with conventional bridgework supported by my remaining natural teeth (if possible)
4. Risks of Implant Treatment:
    a. I have been informed and I understand that surgical risks include, but are not limited to: post operative swelling and limited mouth opening that may last for several days, infection, bleeding, adverse drug reaction, discomfort, bruising, injury to adjacent teeth, perforation of the sinus floor of nose, bone fracture, jaw joint surgery, loss of one or more implants, damage (transient or permanent) to the nerve that gives feeling to the lower lip that could result in numbness, tingling, or other sensation in the lower lip.
    b. I understand that prosthetic risks include, but are not limited to: failure of an implant to fuse or join with the bone (may be immediate or delayed), fracture of the implant and/or implant components, wear of the restoration requiring remake, compromised

esthetic or functional outcome as a result of implant loss or less than ideal angulation or position of the implant(s).

   c. I understand that failing implants would require surgical removal, and may require additional prosthodontic procedures or the subsequent placement of additional implant(s).

5. No guarantee: No guarantee or warranty of any kind has been made to me that the proposed implant treatment will be completely successful or that the final restoration(s) will be totally successful from a functional or esthetic (appearance) standpoint. I understand that no medical or dental procedure is totally predictable and that this includes treatment with osseointegrated implants. I understand that because of unknown or unforeseen factors, further surgical and/or prosthetic procedures beyond those described to me might be necessary.
6. Follow-Up Care: I understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene and maintenance procedures as directed by the doctor, and that I continue follow-up and recall appointments.

Procedure Planned ____

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I understand the doctor may discover other or different conditions that may require additional or different procedures from those planned. I authorize such other procedures as are deemed necessary in my doctor's professional judgment to complete my surgery.

I have had an opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby consent to the placement of implants and the associated prosthetic procedures for restoring the implants.

____ Patient Signature and Date

____ Witness Signature and Date

____ Doctor Signature and Date