Centrum DENTAL CENTRE

9-300 Earl Grey Dr., Kanata, Ontario K2T 1B9

Existing Patients (613) 599-5076 • New Patients (613) 519-3999 • CentrumDental.ca

DENTAL IMPLANT CONSENT FORM

For me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. I have been informed and afforded the time to fully understand the purpose and the nature of the implant surgery procedure to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Procedure: _____

1. My doctor has explained the nature of my condition to me: missing tooth or teeth. I understand what is necessary to accomplish the surgical placement of the dental implant into the supporting jawbone.
2. After a careful oral examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct the doctor and his assistants to treat my condition.
3. I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. Alternative to this treatment have been explained. I have tried to consider these methods, but I desire an implant to help secure the replaced missing teeth.
4. The procedure I choose to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials from human, animal or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage and retention for these teeth.
5. I understand that my gum tissue will surgically be opened to expose the bone and that implants will be placed immediately by threading them into holes that have been drilled into my jaw bone. I understand that the gum tissue will then be stitched over or around the implant to be integrated and permit healing for a period of 4-6 months depending on my personal healing ability. I understand that dentures usually cannot be worn during the first few weeks of the healing phase.
   I have had the opportunity to discuss with my doctor the planned surgical procedure, implant placement, and my post-operative responsibilities. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I understand that following the procedure during the healing process I should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two weeks. I should take any antibiotics prescribed and use pain medication as needed. If I experience an unusual amount of pain I should contact the doctor or his/her associates immediately, as it may signify a problem.
6. I understand that the type of anaesthesia, depending on the choice of the doctor given during surgery and certain prescription medications used after surgery may cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol. Therefore, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anaesthesia or drugs given for my care.
7. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to the drugs, food, insect bites, anaesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
8. If nothing is done, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me. I understand that if I don't have the procedure, the following may occur: further loss of bone or supporting tissues, infection, and looseness of teeth followed by necessity of extraction.
10. During the procedure, the doctor may discover other conditions that require an extension of the planned procedure or a different procedure altogether. I also approve any modifications in design or care in the judgment of the doctor, if it is felt this is for my best interest.
11. I understand no guarantee has been given to me that the proposed treatment will be successful to my complete satisfaction. I also understand that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made. I understand that there will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all the implant. I further understand that should removal be required, the doctor will remove the implant at no additional cost.
12. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment.
13. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

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14. I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected. Success requires my long-term personal oral hygiene, daily plaque removal (brushing and flossing), completion of recommended dental therapy, periodic hygiene visits, regular follow-up appointments and overall general health. There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

15. I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anaesthetics that may later be necessary to correct any complications. I will be liable for all collection costs, including court costs and attorney fees.

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

_____ _____ _____

Patient or Representative Signature | Date | Relationship to Patient

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

_____ _____

Dentist Signature | Date