Allred Dental
955 Boardwalk Suite 103
San Marcos, CA 92078

CONSENT FORM FOR IMPLANT TREATMENT

Treatment consent for patient: _____

I have requested treatment because: _____

My doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant(s) under the gum and/or the bone.

I have further been informed that f no treatment is elected to replace the missing teeth or existing dentures, the non-treatment risks include, but are not limited to:

A. maintenance of the existing full or partial denture(s) with relines or remakes every 3 to 5 years, or as otherwise may be necessary due to slow, but likely, progressive deterioration of the underlying denture-supporting jaw bone:

B. any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time;

C. drifting, tilting and/or extrusion of remaining teeth;

D. looseness of teeth, periodontal disease (gum and bone), possibly followed by extraction(s);

E. a potential jaw joint problem (TMD) caused by a deficient, collapsed or otherwise improper occlusion (bite).

I am aware that the practice of dentistry and dental surgery is not an exact science and **I ACKNOWLEDGE THAT NO GUARANTEES** have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post-surgical dental procedures. I am further aware that there is a risk that the implant surgery may fail, which might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.

_____Initial

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I understand that implant success is dependent upon a number of variables including, but not limited to: operator experience, individual patient tolerance and health, anatomical variations, patient hone care of the implant, and the implant material and design. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.

_____Initial

I have further been informed of the possible risks and complications of implant surgery, anesthesia, and the proposed drugs, including but not limited to: failure of the implant(s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantee about the outcome of this treatment or these procedures. I understand that these complications can occur even if all dental procedures are done properly.

_____Initial

I have been advised that smoking, alcohol or excessive sugar consumption may affect healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my dentist for regular examinations as instructed.

I have also been advised that there is a risk that the implant or associated metal parts may break, which may require additional procedures.

I authorize doctors from the Implant Dentistry Center to perform dental services for me, including implants and other related surgery. I agree to the type of anesthesia that he/she has discussed with me, specifically local, IV sedation or general. I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

_____Initial

I understand that my surgical procedure will be done under _____ anesthesia.

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If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or IV sedation, I further authorize and direct doctors from the Implant Dentistry Center, or assistants of their choice, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure, and I accept the additional cost of the procedure.

_____Initial

I approve any modifications in designs, materials, or care, if my dentist, in his/her professional judgment, decides it is in my best interest to do so.

To my knowledge, I have given an accurate report of my health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or bodily diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my health or any problems experienced with any prior medical, dental or other health care and treatment.

I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records which identify me will be used without my written consent.

I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist and that I understand the risks inherent in doing so.

I agree that if I do not follow my dentist recommendations and advice for post-operative care, my dentist may terminate the dentist- patient relationship, requiring me to seek treatment from another dentist. I realize that ongoing post-operative care and maintenance treatment is critical for the ultimate success of my dental implants.

I have read this booklet and I fully understand the above authorization and informed consent to implant placement and surgery and that all of my questions, if any, have been fully answered. I have had the opportunity to review this form before signing it.

_____ _____
Signature or Patient or Guardian Dated

_____ _____
Witness Dated