



INFORMED CONSENT FOR TWO-STAGE ENDOSTEAL OSTEOINTEGRATED IMPLANTS

This consent form is to educate and inform you regarding your surgery. It does not take away your legal rights.

_____ I hereby authorize Dr. _____ with the aid of his staff to perform surgery to insert a two-stage endosteal osteointegrated implant into areas of teeth #'s _____.

_____ I understand incisions will be made inside my mouth for the purpose of placing one or more endosteal titanium root form structures in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown, denture, or bridge. I acknowledge that Dr. _____ has explained the procedure, in detail. I understand that the crown, denture or bridge will later be attached to this implant by Dr. _____. I understand there will be a separate charge from their office as the cost for that work is not included in the cost of today's procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant may remain covered under the gum tissue for at least three months 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. It has also 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.

_____ I have been informed of the alternatives to the use of an osteointegrated implant, including no treatment at all. The advantages and disadvantages of alternative procedures have been explained to me and I choose to proceed with insertion of the osteointegrated implant.

_____ I also authorize and direct Dr. _____ and his staff to provide additional services as he may deem reasonable and necessary. The performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures may be performed throughout the entire process of treatment. The administration of medications locally, orally, by injection, by infusion, or by other medically accepted route of administration may be prescribed before, during or after surgery. The removal of bone, tissue, or fluids may be used for diagnostic and therapeutic purposes and/or retention or disposal in accordance with usual practices. If any unforeseen condition arises in the course of treatment that calls for the performance of procedures in addition to or different from those now contemplated, and recognized as necessary; and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed necessary. I hereby authorize and designate _____ to give consent to treatment on my behalf whenever possible, should I not be able to.

_____ I understand that there are risks associated with this procedure and these have been explained to me. These complications may require additional medical, dental, or surgical recuperation or treatment at home or hospital. They may include, but are not limited to: swelling, damage to and possible loss of other teeth and dental work, infection or abscess, pain, significant or prolonged bleeding, sinus pain or infection, poor healing, loss of bone, or fracture of the jaw. There is also a possibility of injury to nerves near the treatment site that may cause temporary, or in rare instances, permanent: pain, numbness, or tingling of the lips, chin, tongue, teeth, or face. Other side effects include stretching, cracking or bruising of the lips and corners of the mouth, lessened or lost ability to taste, accidental opening and infection of the normal sinus cavity located above the upper teeth.

_____ I understand that this treatment may not be successful. In the unlikely event a problem during or after surgery occurs causing rejection of the implant, implant removal may be required. Should this occur, I understand that it may be possible to insert another implant after a suitable healing period, and that a separate charge will apply. Also, I understand that every effort shall be made to attain a cosmetic result, but is not guaranteed.

_____ **I understand that my insurance company will not cover dental implants. I am financially responsible for all services rendered. The fees have been explained to me, and I agree to pay a portion today.**

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT. ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN.

Patient's Signature (18 and over) Date

Parent or Legal Guardian Date

Witness Date

Surgery Assistant Date

Albert W. Lin, D.D.S. Date
Robert T. Gramins, D.D.S.
Harrison D. Fortney, D.D.S.