



Queensboro
Oral Surgery Associates

Oral and Maxillofacial Surgery & Implant Surgery
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IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant in the bone. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

2. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are: injury to adjacent teeth, sinus penetration or infection (with upper implants), allergic reactions to drugs, temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck, etc.

3. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that there are no guarantees or assurances as to the outcome of the results of treatment or surgery can be made. There is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant. However, in the event of an implant failure within 2 years of placement, I understand that the doctor will replace the implant without any additional fee, or if I so choose and/or for some reason the implant cannot be replaced, I will be reimbursed 75% of the fee for each failed implant.

4. I understand that implants require a certain amount of natural bone for successful placement. During the surgical phase, if the doctor determines that bone replacement or augmentation is necessary, he has my permission to do so at that time. I understand that there will be an additional fee for this service. I also understand that due to severe limitations of available bone during the time of initial surgery, it may not be possible to place the implant(s) at that time.

5. I understand that the fee does not include any posts or fixation devices other than the healing posts which will be inserted during the second surgical stage.

6. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions and I have been advised that poor hygiene may cause gum or bone infections which may result in premature loss of my implant. I agree to report to my general dentist for regular x-rays, examinations and cleaning as instructed.

7. Anesthetic risks include soreness, bruising, infection, prolonged numbness, allergic reactions, heart attack or stroke. When medications are placed in a vein there may be inflammation at the site of injection (phlebitis) which may cause prolonged discomfort and may require additional care. If I am to have sedation or general anesthesia, I understand that I should not consume food or beverage for 6 hours prior to surgery unless advised differently by the doctor. I also understand that a responsible adult must accompany me to my appointment or drive me home after intravenous sedation or general anesthesia.

8. Medical Risks: There may be certain medical conditions that interfere with the healing or long term health of the implants. I have discussed this with the doctor and have decided that the benefits derived from implants outweigh whatever risks that may exist. I also understand that in rare instances, surgery can exacerbate my condition and further medical attention may be necessary.

9. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, conditions may become apparent which warrant, in the judgment of the doctor, additional alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Patient

Doctor

Date

Witness