SALMONARM Dental

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IMPLANT PATIENT INFORMATION AND CONSENT FORM

PATIENT INFORMATION

Legal Name:_____ ❑Male ❑Female
Last First Middle

Preferred Name:_____Date (D/M/Y):_____

Tooth Replacement Area:_____

I have been informed and I understand the purpose and the nature of the procedures that will be used in the dental implant surgery. I understand what is necessary to complete the placement of the implants into the bone. Whenever extractions are done concurrently with implants, I give my approval to the doctor to perform as needed._____

I have reviewed my medical history with my doctor, including medications, allergies, recreational drugs and other medical conditions. **I AM NOT TAKING MEDICATION RELATED TO OSTEOPOROSIS**._____

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 i have had to drugs, food, insect bites, anaesthetics, pollen, dust, blood, or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health._____

My doctor has carefully examined my mouth and has explained the alternatives to this treatment, including bridge and denture options. I have considered these options and desire dental implants._____

I have further been informed of the possible risks and complications involved with surgery, drugs, and anaesthesia. I understand that such possible complications include pain, swelling, infection and discolouration. Numbness of the lip, tongue, chin, cheek, or teeth may also occur. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reactions to drugs or medication used, etc. The exact duration of these complications may not be determinable and may be irreversible._____

I understand that the risk of no treatment, may include: Loss of bone or gum tissue, inflammation, infection, and nerve sensitivity. Also Possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles and exhausted muscles when chewing._____

My Doctor has explained that there is no method to accurately predict the gum and bone healing capability in each patient after the placement of the implant._____

Continued on other side……

It has been explained that, while implants normally have an extremely high long term success rate, in some instances, implants fail and must be removed. I have been informed and I understand that, due to the nature of the treatment, and the number of factors involved in the success of said treatment, no guarantees or assurances can be made for the outcome of treatment or surgery. Further I understand that the success of the implants will determine the design of the final restorations being placed and whether it will be permanently fixed or removable._____

I recognize that extensive use of smoking, alcohol, recreational drugs, or sugar may affect healing and may limit the success of the implant. I agree to follow my doctor's home care instructions and agree to report to my doctor for regular examinations as instructed._____

I understand that my implants, like my teeth require regular exams and cleanings, in order to prevent gum disease and bone loss, and that if I do not come for regular care of my implants and teeth that gingivitis and peri-implantitis may lead to the eventual loss of my implant._____

I understand that failing implants would require surgical removal and may require additional prosthodontics procedures or the subsequent placement of additional implants._____

I agree to the type of anaesthesia, depending on the choice of the doctor. I understand that I must not operate a motor vehicle or hazardous device for at least 24 hours or more until I have recovered from the effects of the anaesthesia or drugs administered fro my care._____

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided that my identity is not revealed._____

I request and authorize that medical/dental services, such as implants and other surgery may be done for me. I fully understand that during and following the intended procedure, surgery, or treatment, conditions may become apparent which will demand the judgement of the doctor and additional or alternative action needed, such as **BONE GRAFTING** procedures to ensure the success of comprehensive treatment. I also approved of any changes in design, materials, or care, if it is felt needed for my best interest._____

I have had ample opportunity to read this form and ask any questions, and had my questions answered satisfactorily.____

_____	_____	_____
Print Name	Date	Signature
_____	_____	_____
Doctor	Date	Signature