DR. Russel Kearl

TEL: (250)832-3633 FAX: (250)832-9417

IMPLANT PATIENT INFORMATION AND CONSENT FORM FOR

Name: _____
Date: _____
Tooth Replacement Area: _____

I have been informed and I understand the purpose and the nature of the procedure's that will be used in the dental implant surgery. I understand what is necessary to complete the placement of implants into the bone. I AM NOT TAKING MEDICATION RELATED TO OSTEOPOROSIS. Whenever extractions are done concurrently with implants, I give my approval to the doctor to perform as needed.

My doctor has carefully examined my mouth and has explained alternatives to this treatment, I have tried or considered these methods, but I desire dental implants.

I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. 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 medications used, ect. The exact duration of these complications may not be determinable and may be irreversible.

I understand that if nothing is done, any of the following could occur: loss of bone or gum tissue, inflammation, infection and nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains 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 capabilities in each patient after the placement of the implant.

It has been explained that in some instances, implants fail and must be removed. I have been informed and I understand that the practice of dentistry is not an exact science; no guarantees or assurances can be made for the outcome of treatment or surgery.

I recognize that extensive smoking, alcohol or sugar may affect gum 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 agree to the type of anesthesia, 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 anesthesia or drugs given for my care.

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, anesthetics, pollen, dust, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

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.

_____ _____

Doctor **Patient or guardian**

In case of emergencies please call Dr. Kearl at 250-517-8620