Sample Form: Discussion and Consent for Implant Restoration

Patient's Name:_____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with sufficient information, in a way I can understand, in order to make a well informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish,** and that it is better to ask questions prior to treatment than to wonder about it after treatment has started.

Nature of Implant Restoration

Implant restorations replace missing teeth. They differ from conventional restorations in that they are supported by dental implants, rather than by natural teeth. The use of dental implants permits missing teeth to be replaced through the use of crowns, fixed bridges, and dentures that are supported or retained by their attachment to the implant(s).

It has been recommended that I have the following implant-supported restoration(s):

☐ Single crown on implant in the position of tooth #_____
☐ Fixed bridge on implants in the position of teeth #_____
☐ Implant-retained removable partial denture(s) replacing teeth #_____
☐ Implant-retained removable full denture(s) replacing teeth #_____
☐ Other:_____

Implant restorations usually require a number of visits to complete treatment. An impression, or mold, of the top part of the implant, associated restorative components, and surrounding gum tissue is made using a rubbery material. The implant restoration is then made by a dental laboratory. It is important to return for the insertion of the implant restoration as soon as it is ready.

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been considered.

The prognosis, or likelihood of success, of this procedure is _____. However, I understand that no guarantee, warrantee, or assurance has been given to me that this treatment will be successful, or for how long.

My implant restoration(s) is (are) estimated to cost $_____ and estimated to take _____ visit(s) to complete over a period of _____ weeks/months.

Alternatives to Implant Restoration

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to implant-supported tooth replacement. I understand that possible alternatives to an implant-supported prosthesis may be:

- **Replacement of the missing tooth or teeth by a tooth-supported fixed bridge.** Natural teeth next to the toothless space are used to support a bridge, which is cemented into place and is non-removable. This procedure requires drilling the natural teeth to properly shape them to support the fixed bridge.
- **Replacement of the missing tooth or teeth by a removable partial denture or full denture.** Partial and full dentures are removed from the mouth for cleaning. They are supported by the remaining teeth and bone and retained by the remaining teeth, cheeks, lips, and tongue.
- **No treatment.** I may decide not to replace the missing tooth or teeth. If I decide upon no treatment, my teeth may shift over time, causing chewing or gum problems.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.
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Risks of Implant Restoration

I have been informed and fully understand that there are certain inherent and potential risks associated with implant restorations. I understand that I may experience pain or discomfort during and/or after treatment. I understand that an implant restoration may not relieve my symptoms or meet my expectations for comfort, function, or esthetics. I understand that I may notice slight changes in my bite. I understand that during and for several days following treatment, I may experience stiff and sore jaws from keeping my mouth open.

I understand that it is possible for an infection or other problems to occur in or around an implant site and/or the surrounding gums, and that I may need antibiotics and/or other procedures, such as periodontal (gum) surgery around the implant, to treat the infection. I understand this may occur during or after treatment. I understand that my gums may recede after the completion of my implant restoration. This condition may also require periodontal (gum) surgery. I understand that poor eating habits, poor oral habits (smoking, tobacco chewing, fingernail biting, etc.), poor oral hygiene, and certain medical conditions or medicines will negatively affect how long my implant restoration lasts.

I understand that I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

Other foreseeable risks not stated above include:_____

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____.

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Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the procedure.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the recommended treatment.

_____ I understand this treatment can also be performed by a prosthodontist (dental restoration specialist).
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I understand the risks associated with this treatment and elect to have this procedure performed by Dr. _____. I understand that if any unexpected difficulties occur during treatment, I may be referred to a prosthodontist for further restorative care.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness