Sample Form: Discussion and Consent for Implant Placement Surgery

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 Placement Surgery

Dental implants are devices that are surgically placed in the jaw that become attached to the bone as substitutes for natural tooth roots. Implants permit missing teeth to be replaced through the use of crowns, fixed bridges, or dentures, which attach to the top(s) of the implant(s). It has been recommended that I have a total of ________ dental implant fixtures placed in the following tooth positions or areas of my mouth:____.

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.

Implant placement surgery involves opening the gums and creating a hole in the jawbone for each dental implant. The dental implant is placed snugly in the custom hole created for it. In some cases, an implant may be placed into a tooth socket at the time a tooth is extracted. The gums are then stitched closed over the implant. Follow-up visits are required. Following placement, implants require time to heal and attach to the surrounding bone before replacement teeth can be made to fasten on top of them. I understand my expected healing time will be ________ months. During this time, I may be without replacement teeth. A second surgery is then necessary to uncover the implant and prepare it for use.

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(s) is (are) estimated to cost $________ and estimated to take ________ visit(s) to complete. After implant placement, it is estimated that I will be able to proceed replacing my missing teeth in ________ months.

Alternatives to Implant Placement Surgery

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to implant placement and implant-supported tooth replacement. I understand that possible alternatives to an implant-supported restoration 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.
- **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 ______________________________________.
Patient's Initials

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Risks of Implant Placement Surgery

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including surgical implant placement. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, and/or bruising, all of which may last for several days. I understand that it is possible for an infection to occur in or around the implant site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure and sinus infection (upper arch); limited ability to fully open your mouth; soreness in the jaw joints (TMJs).

I understand that the implant(s) may fail to properly attach to the surrounding bone and may require removal. I understand that this may occur for unknown reasons. I understand that the use of tobacco products (smoking or chewing), and certain medical conditions or medicines will increase the risk that the implant(s) will fail and will require removal. I understand that poor eating habits and poor oral hygiene may negatively affect how long my implants last. I understand that the design and construction of my replacement tooth or teeth may contribute to implant failure.

I understand that implants may need to be placed very close to nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. I also understand that following implant placement surgery, I may have nerve disturbances such as temporary or permanent pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues. I understand this risk is greater in the lower jaw.

I understand that additional surgical procedures may be necessary based on findings and observations revealed during surgery that are not now known.

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 and surgery is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or 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 an oral surgeon or a periodontist (dental specialists).
Patient's Initials
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 an oral surgeon or periodontist for further surgical care

Signed:____ Date:______________________________
Patient or Guardian

Signed:____ Date:______________________________
Treating Dentist

Signed:____ Date:______________________________
Witness

This sample form is for illustrative purposes only. Your clinical procedures and risks may be different than those described. We encourage you to modify this form to suit your individual practice and patient needs. The information contained in this document is not intended as legal advice. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice. Published by CNA and provided through the Dentist's Advantage insurance program and the National Society of Dental Practitioners. Copyright © 2019 CNA. All rights reserved. Published 5/19.