*Advanced Dental Care of Englewood*
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## DENTAL IMPLANT CONSENT

Patient name : _____ Date of birth : _____

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. I request and authorize Dr. or his/her associates or assistants to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications which have been explained to me.

3. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications include the very rare potential of risks or complications, such as damage to vital organs including the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.

4. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following:

- Postoperative pain, discomfort and swelling
- Bleeding
- Postoperative infection
- Injury or damage to adjacent teeth or roots of the teeth
- Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling
- or pain of the chin, lips, cheek, gums or tongue
- Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw — temporomandibular joint (TMJ) syndrome
- Fracture of the jaw
- Bone loss of the jaw
- Penetration into the sinus cavity
- Mechanical failure of the anchors, posts, or attached teeth

• Failure to implant itself
• Allergic or adverse reaction to any medications

Most of these risks, complications or side effects are not serious and do not occur frequently. Although these risks, complications and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization or blood transfusions. Very rarely, the potential risk and complications could result in permanent numbness, disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment as required.

5. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

*Patient/Legally Authorized representative signature :* *Date :*

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