Informed Consent for Dental Implant Procedure

Patient's Full Name: _____

My dentist has provided a comprehensive explanation regarding my current dental situation: Missing tooth or teeth.

The proposed intervention to address or diagnose my condition is: Dental implant placement.

This entails: Surgically embedding an implant into the supporting jawbone.

- **I have been briefed on alternatives to this treatment.**

- **I acknowledge that neither the dentist nor the implant manufacturers have made any guarantees regarding the outcome, as cosmetic results may vary based on individual circumstances. In case of implant failure, any additional fees will be at the discretion of the dentist. The disclosed fee is acceptable to me, and I understand that I am responsible for payment regardless of dental insurance coverage.**

- **I am aware that the purpose of the dental implant is to provide support for a crown, bridge, or denture.**

• I understand that the surgical procedure involves both implant placement and, potentially, a subsequent procedure to expose the implant and attach the necessary components for the prosthetic restoration.

• Without intervention, potential consequences may include bone disease, gum inflammation, tooth sensitivity, and other oral health issues.

• I trust that the dentist will exert professional expertise to achieve the desired results.

While patient education is crucial, legal requirements necessitate extensive disclosure of potential surgical and anesthetic risks, although many are improbable. Please feel free to inquire about the frequency of any disclosed risks based on our clinical experience.

• Common risks include restricted mouth opening, gum shrinkage, temporomandibular joint discomfort, and temporary tooth sensitivity. Less common risks involve permanent nerve injury and interference with speech.

• In the event of complications necessitating additional surgery or implant removal, no

refunds will be provided. However, if removal becomes necessary, the dentist will perform it at no extra cost. Any external removal procedure will be the patient's financial responsibility.

• Various medications and anesthesia may cause adverse reactions, ranging from mild discomfort to severe complications. Precautions, including arranging transportation and post-procedure observation, are necessary.

• During the procedure, unforeseen conditions may require procedural adjustments, which I authorize the dentist to perform.

• Regular follow-up appointments are essential for oral hygiene maintenance and implant evaluation. Failure to adhere to these appointments absolves the dentist of liability for implant failure.

• I confirm understanding of the fees and acknowledge responsibility for payment, regardless of insurance coverage.

• Prosthetic treatments will be handled by the restorative dentist, and associated fees are separate from the implant placement cost.

By signing below, I authorize the designated dentist to proceed with the aforementioned procedure.

_____ _____ Patient's Signature Date

If signing on behalf of the patient, specify the relationship:

_____

I, the undersigned dentist, have provided detailed information regarding the condition, procedure, risks, and alternatives outlined in this form.

_____ _____ Dentist's Signature Date