CONSENT FOR DENTAL IMPLANTS

Patient: _____
Implant(s): _____

1. I hereby authorize Dr. Everett and any other doctor of his surgical team as selected by him to perform surgery upon me (or upon the person identified as the patient, for whom I am empowered to consent), to extract an existing tooth/teeth if necessary and insert a dental implant/implants in my upper and/or lower jaw.
2. I understand incision(s) will be made inside my mouth for the purpose of placing one or more titanium dental implants in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown, denture or bridge. **I also understand a bone regenerative material may be placed around the implant due to insufficient bone present to fully cover the implant/implants. Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes may be used with or without graft material to aid in bone regeneration.**
3. I acknowledge that Dr. Everett has explained the procedure in detail. I understand that the crown, denture or bridge, will later be attached to this implant by Dr._____ and the cost for that work is **not included** in the charge for this procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the dental implant(s) will be required to heal for a period of 3 to 6 months before it/they can be restored with a crown(s). I also understand that there will be no refund of the fees in the event of a failure. It has also been explained to me that once the dental implant is inserted, the entire dental treatment plan, including my own oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.
4. I have been informed of the alternatives to treatment other than, or in addition to a dental implant, including no treatment at all; dental bridges, crowns or partial dentures.
5. I understand that, if I desire or if Dr. Everett advises, sedative drugs may be used to reduce my anxiety and discomfort by making me relaxed and sleepy. Be advised that this type of sedation, conscious sedation, **is not** general anesthesia. **You will be sedated but conscious and may be aware of your surroundings**. These drugs may also reduce my ability to remember events occurring on the day of the operation. I understand and agree that if sedative drugs are required before or during surgery, **I will not drive** myself home following surgery, but will arrange to be driven and accompanied home. I agree not to operate a motor vehicle or hazardous machinery for at least 24 hours following surgery. The side effect of any intravenous infusion may include nausea and vomiting and seen most frequently is phlebitis. This side effect occurs in 1 to 4 percent of patients. Phlebitis is a raised, tender, hard inflammatory response, which can have onset from 24 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm, moist heat, yet tenderness and a hard lump may be present for up to a year. Intravenous anesthesia is a serious medical procedure and although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.
6. I also authorize and direct Dr. Everett and his associates to provide such additional services as he or they may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents, the performance of necessary laboratory, radiological (X-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion or by other medically accepted route of administration; and the removal of bone, tissue, and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices. If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed necessary and advisable under the circumstances with the exception of _____ (if none, put "none"). Prior to performing such additional or different procedures, however, I desire that they be discussed with _____ (relationship :_____), whom I hereby authorize and designate to give consent to treatment on my behalf whenever possible.
7. I understand that there are risks associated with this procedure and these have been explained to me. They may include, but are not limited to, swelling; damage to and possible loss of other teeth, fillings or other dental work; infection or abscess; pain; significant bleeding which may be heavy or prolonged; sinus or nasal problems or infection; poor healing; loss of bone; fracture of the jaw; injury to the nerves near the treatment site which may cause pain, numbness or tingling of the lips, chin, face, mouth, teeth and tongue (which is <u>usually temporary, but</u> may be permanent); loss of or damage to the ability to taste; stretching of the corners of the mouth with resultant

may be permanent), loss of or damage to the ability to taste, stretching of the corners of the mouth with resultant cracking and bruising; accidental opening and infection of the normal sinus cavity located above the upper teeth. Infection may result in ensuing rejection of bone grafting and/or implant. Although a good cosmetic result is hoped, it cannot be guaranteed. I also understand that any of these treatment complications may necessitate additional medical, dental, or surgical recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure, which may prevent placement of the implant, and that rejection of this implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period and that a charge will be made for this procedure.

I certify that I have had an opportunity to read and fully understand the terms and words within.

The above consent to the surgical procedure and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and also state that I read and write English.

SIGNATURE: DATE:

PRINTED NAME: DATE:

WITNESS: DATE: