Implant Consent Form

*I have been informed of the purpose and the nature of the implant surgery procedure. I understand what it is necessary to accomplish the placement of the implant under the gum or in the bone.

*Alternative treatment, such as partial dentures, has been explained. I understand that no treatment is also an alternative. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth. The benefits of the implants include no need for partial dentures, no need to cut down teeth for a fixed bridge and the ability to chew food more effectively.

*I have further been informed of the possible risk of excessive bleeding and infection. This risk is very low by following the treatment plan. The possibility of permanent numbness does exist.

*It has been explained that in some instances implants fail and must be removed. No guarantees or assurances as to the outcome of results of treatment or surgery can be made. Success rate on upper implants is 85 to 90 percent. On lower implants, the success rate is about 95 percent. It has been explained of the possibility for fracture of the implant after restoration, though it only happens in 1 to 3 percent of the cases.

*I understand that excessive smoking, alcohol or sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

*The fee charged is for surgical placement of the implants. My restorative dentist will have an additional charge to place the teeth on top of the implants.

*To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

*I give permission to Dr. Walsh and his clinical team to take any necessary diagnostic x-rays, photos or study models to enable complete diagnosis and treatment. I also give permission for any x-rays, photos or study models to be used for educational purposes, provided my identity is not revealed.

*I understand that during and following surgery conditions may become apparent which warrant additional or alternative treatment. An example of this would be other teeth shifting in the mouth during implant therapy.

*I understand that by retaining teeth which are hopeless, I am risking infection and loss of the dental implants.

I have read and I understand the above.

Patient _____ Date _____

Dentist _____ Date_____