ORAL SURGERY ASSOCIATES AND DENTAL IMPLANT CENTERS

A Professional Association

Members of the American Association of Oral and Maxillofacial Surgeons

Members of the Georgia Dental Association

CONSENT FORM FOR DENTAL IMPLANTS

I, _____, hereby authorize Dr. Gordon L. Brady, Dr. Richard S. Singer, Dr. Robert Going, Jr. Dr. Brett C. Gray, Dr. Steven P. King, Dr. Fulton D. Lewis III, Dr. Steven D. Pollack, Dr. Brenda J. Hall, Dr. Mollie A. Winston, Dr. Scott E. Tate and any other agents or employees of Oral and Maxillofacial Surgery Associates, A Professional Association, and such assistants as may be selected by any of them, to treat my condition(s).

Diagnosis. After a careful oral examination and study of my dental condition, my doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

Recommended Treatment. In order to treat my condition, my doctor has recommended the use of root form dental implants. This procedure has a surgical phase, which may consist of multiple surgeries, followed by a prosthodontic or restorative phase. I understand that from start to finish this treatment may take anywhere from four to eighteen months or more. The planned treatment is:

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Surgical Phase of Procedure. I understand that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will be placed into holes that have been drilled in my jawbone. The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of three to twelve months. I understand that dentures usually cannot be worn during the first two weeks of the healing phase.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my doctors will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants. I agree to use of bone grafts from my body and cadaver bone from the tissue bank.

For implants requiring a second surgical procedure, the overlying tissues will be reflected and the stability of the implant will be verified. If the implant appears satisfactory, an attachment, which will protrude through the gum tissue will be connected to the implant. Procedures to create the implant tooth/teeth replacement can then begin.

Prosthodontic Phase of Procedure. I understand that at this point I will be referred back to my restorative dentist or to a Prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthodontic device will be attached to the implant. This procedure should be performed by a person trained in the prosthodontic protocol for the root form implant system.

Expected Benefits. The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

Principal Risks and Complications. I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the implant surgery or the drugs and/or the anesthetics used. These complications include, but are not limited to: post-surgical infections; bleeding; swelling; pain; facial discoloration; transient, but on occasion, permanent numbness of the lip, tongue, teeth, chin or gums; jaw joint injuries or associated muscle spasm; transient, but on occasion, permanent increased tooth looseness and/or tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gums upon healing resulting in elongation of some teeth and greater spaces between some teeth; cracking or bruising of the corners of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; injury to teeth; bone fractures; nasal sinus penetrations; delayed healing and/or accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

I understand that the design and structure of the tooth/teeth replacement can be a substantial factor in the success or failure of the implant I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

Alternatives to Suggested Treatment. Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures - - depending on the circumstances. However, continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissue of my mouth.

Necessary Follow-Up Care and Self-Care. I understand that it is important for me to continue to see my doctor. Implants, natural teeth and prostheses have to be maintained daily in a clean, hygienic manner. Implants and prostheses must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my treating dentists.

No Warranty or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, success cannot be predicted with certainty. There exists the risk of failure, relapse, additional treatment or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records. I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purpose. However, my identity will not be revealed to the general public without my permission.

I agree and understand I am not to have and/or have not had anything to eat or drink for eight (8) hours before my surgery if I am going to be put to sleep.

I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph 1, and to the use of such anesthetics as may be deemed advisable with the exception of:_____ to which I said I was allergic.

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and the benefits of the surgery, the alternative treatments available, and the necessity for follow-up care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns. After thorough deliberation, I hereby consent to the performance of dental implant surgery.

I also consent to use of an alternative implant system if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of the implants, I defer to my doctor's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts or membranes to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

{X_____} Date:
Patient's/Parent or Legal Guardian (if under 18)

{X_____} Date:
Witness (Professional Staff Member)