ORAL SURGERY ASSOCIATES
& DENTAL IMPLANT CENTERS

I, _____ herby authorize _____ and request and/or his designees to perform the following oral and maxillofacial procedure(s):

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In the event of unforeseen circumstances, I consent to the performance of such additional and alternative procedures as in the judgment of the above doctor(s) may be necessary to restore and/or preserve my overall health.

Extractions

I understand that the following procedure I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow the extractions and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen.

I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my doctor of all medications I am currently taking. I understand that holding my mouth open during treatment may temporarily leave my jaw felling stiff and sore and may make it difficult to open wide for several days. However, this can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise.

Implant Placement

Dental implants are titanium anchors placed into the jawbone, underneath the gum tissue, to support artificial teeth where natural teeth are missing. When the bone attaches itself to the implant, these implants act as tooth root substitutes and form a strong foundation to stabilize the customized, artificial teeth.

1. Multiple implants will be placed using surgical guides with or without incisions.

2. *IMPLANT SUCCESS*. I understand that for implants to be successful, they must bond directly to the jawbone (called osseointergration). It has been explained to me that implants are not 100% successful and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implants or will be removable by me. I understand that a medical condition, such as uncontrolled diabetes can compromise the Osseointergration and longevity of an implant.

3. I realize that it is my duty to adhere to the oral hygiene maintenance procedures recommended by the staff in order to maintain optimal oral health and that crowns and bridges are susceptible to periodontal breakdown. I must keep my implants and prosthesis clean by daily maintenance as well as regular checkups and cleanings at my dentist's office. Strict oral hygiene maintenance protocol should help to preserve the long-term success of prosthodontic treatment; however it cannot be guaranteed or warranted.

4. *TREATMENT*. I understand the procedure I am agreeing to undergo is different than the old, standard two-stage dental implant procedure but that research on "immediate loading" (putting teeth on the implants) has demonstrated that this is an effective treatment method.

5. There will be costs involved in maintaining this restoration including cleanings, comprehensive maintenance, hygiene recall programs, replacing seals and possible repairs. Repairs and replacement of worn or fractured materials relating to the implant and/or the implant supported prosthesis will be my financial responsibility.

6. *ALTERNATIVES TO IMPLANTS.* I have considered the following alternative to implant treatment:
   A. No treatment
   B. Construction of conventional complete or partial denture(s).
   C. Tooth replacement with conventional bridgework supported by my remaining natural teeth (if possible).

7. RISKS OF IMPLANT TREATMENT. I have been informed and I understand that the risks of no treatment include, but are not limited to, continuing use of removable partial or complete dentures with associated potential for discomfort and shrinkage of

the jawbones which would require periodic relining or remaking of the denture(s); periodontal disease which could lead to the loss of teeth if not treated.

8. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to the following:

A. Postoperative discomfort and swelling that may necessitate several days of recuperation. Postoperative infections that may require additional treatments.
B. Gingival irritation and bleeding from the preparation site that may be prolonged.
C. Injury to adjacent teeth, fillings, crowns, and soft tissue.
D. Restricted mouth opening for several days or weeks. Stretching the corners of the mouth resulting in cracking and bruising.
E. Cardiac Arrest.
F. Perforation of the sinus or floor of the nose.
G. Damage (temporary or permanent) to the nerve that gives the feeling to the lower lip, chin, or tongue which could result in numbness, tingling or other sensations in the lower lip, which could be permanent.
H. Bone or jaw fracture.
I. Jaw joint injury (TMJ)
J. Other: _____

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I understand that prosthodontic risks include, but are not limited to, failure of an implant to osseointergrate (may be immediate or delayed), fracture of the restoration and/or implant components, wear of the restoration and/or implant components, wear of the restoration requiring remake, compromised esthetic or functional outcome as a result of implant lose or less than ideal angulation or position of the implant(s).

I understand that my tongue will need to adapt to changes in my mouth/ teeth which may affect my speech until the tongue accommodates the change. I understand that failing implants would require surgical removal and may require additional prosthodontic procedures and/or the subsequent placement of additional implant(s).

9. *RISKS OF SMOKING*. The most common complication associated with dental implants is problems with implant integration; that is the failure to fuse with the bone and this often leads to implant failure. This complication becomes even worse if the person undergoing implant surgery is a smoker. Dental implants need oxygen to fuse correctly with the bone. If there is not a good blood flow to the tissues and bone, the implant may not be able to stay in proper place. Remember nicotine found in tobacco has a negative effect on blood flow that makes bone healing after implant surgery even more difficult. I understand the harmful effects of smoking and have been advised that I cease smoking prior to surgery in order to prevent the toxic chemical effects on healing tissues. I also understand that it has been recommended that I should discontinue the use of tobacco, nicotine replacement medication, patches, lozenges, vapes, and anything that has nicotine until the final prosthesis is delivered. This is the biological rationale and any deviation from this could jeopardize the success of my dental implants.

10. I consent to 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 (none or name of particular anesthetic).

11. Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any motor vehicles, automobile, or hazardous mechanical devices, or work while taking such medications and/or drugs; or until fully recovered from the effects of same.

12. *NO GUARANTEE*. No guarantee or warranty of any kind has been made to me that the proposed implant treatment will be 100% successful or that the final restoration(s) will be totally successful from a functional or esthetic (appearance) standpoint. I understand that no medical or dental procedure is totally predictable and that this includes the treatment with dental implants. I understand that because of unknown or unforeseen factors, further surgical and prosthodontic procedures beyond those described to me might be necessary. I also consent that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene procedures directed and that I return for scheduled follow-up and recall appointments.

I have had the opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby consent to the placement of implants in my mouth, and the associated prosthodontic procedures for restoring the implants.

Photographs

I consent to use, reuse, productions and reproduction at any time by Oral Surgery Associates & Dental Implant Centers or their designees, my likeness or resemblance as presented in photographs of my oral and facial structures and their publication on the Internet, on audio/video or other forms of recording and in printed format for public and professional educational and scientific purposes. My name will not be revealed without my consent. I represent that I am over twenty-one years of age.

I have read and understand the treatment described and I have no additional questions.__{X____}___

PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THE CONSENT FORM.
I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ THIS CONSENT AND THAT I FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO THE PROCEDURE. I UNDERSTAND THE EXPLANATION REFERRED TO OR MADE. ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN, AND IN APPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I READ AND WRITE ENGLISH.

{X_____} Date:
Patient/Parent or Legal Guardian (If under 18)

{X_____} Date:
Witness (Professional staff members)

{X_____} Date:
Surgeon