IMPLANT PROSTHETIC CONSENT TO TREATMENT

1. I, ______________, authorize Dr. ______________ to construct a dental prosthesis for use with my implant(s).

2. Alternatives to an implant supported and/or retained prosthesis have been explained to me. I have tried or considered these alternative treatment methods and their risks, but I desire an implant and implant prosthesis to secure and/or replace my missing teeth.

3. As with any dental prosthesis, there are possible complications of which I should be aware. These include, but are not limited to:
   - Risk of prosthetic and/or material failure;
   - Loss of permanent teeth;
   - Loss of prosthesis and/or implant due to periodontal disease, other oral disease, or oral manifestations of systemic disease;
   - Compromised bite relationship;
   - Compromised esthetics.

   The development of any of these risks may result in the need for surgical removal of the implant and the use of alternative forms of treatment. I have been advised that bone grafting and/or guided tissue regeneration may be necessary.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant prosthesis. I am aware that the implant surgery and/or prosthesis may fail, which may require corrective surgery or the removal of the prosthesis or implant with possible surgery associated with the implant removal.

5. I have been advised that the use of tobacco or alcohol may affect the implant and/or the prosthesis and limit the success of this treatment. My dentist has provided instructions for home care and oral hygiene and I understand the importance of following my dentist’s instructions for professional dental cleaning, as well as follow-up care and treatment.

6. I agree that I have read, had explained to me and understand the consent to an implant prosthesis. I have been given the opportunity to ask questions concerning the nature of the treatment and the risks involved. I consent to the procedure knowing it has risks and limitations.

PATIENT ___________________________________________________________ DOCTOR ___________________________________________________________

WITNESS (if available) _______________________________________________ PARENT OR GUARDIAN (if minor) ______________________________________

DATED: ____________________ TIME: ____________________

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