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AGREEMENT AND CONSENT FOR PLACEMENT OF DENTAL IMPLANTS

PATIENTS NAME:___________________________________CHART #__________DATE:___________________

1. This is my consent for Dr. Bradshaw/Dr. Lubritz, and my restorative dentist__________________ who is working with him/her to perform surgery upon me, to insert metal root from dental implants in my upper and/or lower jaw as follows:Bone or soft tissue grafting (as applicable):____
____

2. I understand that incisions(s) will be made inside of my mouth for the purpose of placing one or more metal root form structures in my jaw(s) to serve *as* anchors) for a missing tooth or teeth or to stabilize a crown(cap), denture or bridge. I acknowledge that Dr. Lubritz/Hanna (surgeon) have explained the procedure, including the number and location of the incisions to be made. I understand that the crown (cap), denture or bridge will later be attached to this implant by my restorative dentist and that the cost for all restorations are <u>not included</u> in the charge for this procedure. I also understand that the implant(s) may last for many years but that no guarantee of success for any specific period of time can be or has been given. I have been informed that the implants(s) must remain covered under the gum tissue for three months or more before use and that a second surgical procedure is usually required to uncover the top of the implants) for attachment of connector devices which will be used for retention of the planned dental prosthesis (cap, denture, or bridge). It has also been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implants) may fail.

3. I understand an Early Failure of an implant may occur due to:

<u>(a) Non-restorable (due to position).</u> - Despite the best efforts to place dental implants in ideal position, I understand that in some cases the final location of the implant(s) as dictated by available bone and other factors may result in a position that is non cosmetic and/or functional

(1) If a new implant can be placed and I desire to proceed with additional surgery, the procedure will be done at no additional cost Any costs associated with grafting will also be at no additional charge. Intravenous sedation employed during the second surgical procedure, if desired, will be at the usual fee.

(2) If a new implant can be placed and I do NOT desire to undergo additional surgery, I will receive a refund of 50% of the surgical fees only. No **refunds or discounts will be given for graft-related biomaterials or intravenous sedation, if they were used during the initial surgery.**

<u>(b) Failure to Osseointegrate (the bone does not attach to the implant):</u> I understand that Implant success is based on:

(1) quality and quantity of bone, (2) posterior location in the mouth, (3) location of vital structures and (4) infection. Should an implant fail to osseointegrate and a new implant can be placed, the implant will be replaced at a reduced free of 50% per implant. Any additional grafting procedures required to remedy the situation will be at 50% of usual fees. Intravenous sedation, if desired, will be charged at the usual fee. **No refunds or discounts will be given for intravenous sedation or bone grafting materials associated with the initial surgery.**

<u>*(c)* **High Risk Conditions**</u>

I acknowledge that one or more of the following conditions exist(s) in my case and understand that because of this/these conditions(s), a higher risk of failure of implants exists.

____I. Connective Tissue Disorders _____II. Diabetes Mellitus ___III. Head and Neck Cancer Radiation
______IV. Immunocompromised Health Status ____V. Osteopenia/Osteoporosis ____VI. Smokers
VII Other:_

I understand that if the Implant fails, no refund for the implant and/or associated grafting fees or intravenous sedation will be given. Any attempts at re-operation will be carefully re-evaluated. <u>(d) **Earlv Loading Failure**</u>

I understand that implants may initially demonstrate successful osseointegration, however, after being placed into functional use, may show signs of failure (i.e. significant bone loss or loosening). If this occurs in the first 6 months after loading, the implant(s) will be replaced at a reduced fee of 50% per implant. Any additional procedures (i.e. grafting, intravenous sedation) will be at the usual fee.

4. I understand a **Late Failure** (after 6 months in function) of an implant may occur due to:

(a) Gum and bone infection around the implant (peri-implantitis). (b) Poor oral hygiene and/or (c) Biomechanical loading effects.

Usual fees will apply after six months in function to repair or replace the implant(s).

5. I have been informed of the alternatives to the use of dental implants, including no treatment at all, use of partials, bridges, and dentures, and construction of a new ridge of my upper or lower jaw by means of vestibuloplasty (plastic surgery on the gums), skin and bone grafting or placement of synthetic materials and implantation of another type of implant. The advantages and disadvantages of each of the above procedures have been explained to me and I choose to proceed with insertion of the dental implant(s) described above.

6. Dr. Bradshaw/Dr. Lubritz have explained to me that there are certain inherent and potential risks in any treatment or procedure and that in this specific instance such operative risks could include but are not limited to:

a. Post-operative discomfort & swelling that may necessitate several days of home recuperation
b. Damage to and possible loss of other teeth, fillings or other dental work
c. Significant bleeding that may be heavy or prolonged.
d. Postoperative infection or abscess requiring additional treatment This
may result in the loss of bone grafts and/or implants (s).
e. Opening of the sinus (a normal cavity situated above the upper teeth) possibly resulting in infection or requiring additional surgery.
f. Poor or delayed healing which may result in additional surgical procedures.
g. Fracture of the jaw.
h. Injury to nerves near the treatment site, which may cause pain, numbness or tingling of the lips, chin, face, mouth, teeth and/or tongue.
i Loss or reduction in the ability to taste.
j. Stretching the corners of the mouth with the resultant cracking and bruising.
k . Loss of the dental implant due to failure to osseointegrate.
j. Other:__________________________________

I also understand that any of these treatment complications may necessitate additional medical, dental or surgical recuperation at home or even in the hospital.

7. Because successful treatment often depends upon the compliance with a doctor's instructions, I agree to cooperate completely with the recommendations of the doctor and/or his/her assistant while I am under his/her care, realizing that any lack of same could result in a less than optimum result.

8. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. **Although a good cosmetic result is desired, it cannot be guaranteed.** 1 have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of one or more implants and that rejection of any implant is possible, which would necessitate its removal. Should this occur, I understand that it may be possible to insert another implants) after a suitable healing period and that a charge must be made for this procedure.

9. I understand that any treatment of the implant and/or surrounding bone or gum tissue AFTER the prosthesis has been placed will be considered maintenance therapy and will be at an additional charge.

10. **ANESTHESIA:** (If you have opted to have your surgical procedure performed using intravenous drugs or oral sedation, the following applies) I agree and understand that I am not to have and/or have not had anything to eat or drink for __hours before my surgery. 1 consent to administration of such local anesthesia (numbing injections) and/or sedation and/or general anesthesia as deemed necessary by the doctor and/or his/her designated assistants to accomplish the proposed procedure as discussed with me.

a. 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 vehicle, automobile or hazardous devices or work while taking such medications and/or drugs or until fully recovered from the effects of the anesthetic medications and drugs that may have been given to me in the office or hospital for my care. **I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me to my home after my discharge from surgery.**

b. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent to any procedure that requires a general anesthetic, or oral sedation.

c. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he/she may deem advisable.

d. I have had an opportunity to discuss and have made a full disclosure of my past medical and health history including any serious problems and/or injuries. This includes any past or present substance abuse.

11. I consent to the use of Nitrous Oxide (laughing gas).

12. I authorize the making and use of photos, slides, x-rays and TV videotape by this office to be potentially used for educational or professional purposes. If any of these are to be used for other than educational or professional purposes, then a separate release will be obtained.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, *IF* ANY, WERE STRIKEN BEFORE I SIGNED.

____________________	____________________	____________________
Witness:	**Patient/Guardian**	**Date**
____________________	____________________	____________________
Witness	**Doctor**	**Date**