

**Center for Oral and Facial Surgery
Associates in Oral & Maxillofacial Surgery, P.C.**

CONSENT FOR DENTAL AND JAW IMPLANTS AND ANESTHESIA

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Patient Name: _____ Account #: _____

I hereby authorize Dr. _____ and staff to perform the following procedure: _____ and to administer the anesthesia I have chosen, which is:

local anesthesia nitrous oxide/oxygen analgesia intravenous sedation general anesthesia

1. I have been informed of possible alternate methods of treatment, if any, including:

_____ I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

2. I understand that incision will be made inside my mouth for the purpose of placing implant in my jaw to serve as anchors for missing teeth. The doctor has explained the procedure, the incisions, and the type of implant(s) to be used. I understand that the crown, bridge or denture that is to be attached to the implant(s) will be made and attached by my family dentist and that a separate charge will be made by that office.
3. I understand that after surgery is completed a healing period will take place before any permanent restoration will commence. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If the planned schedule is not carried out, the implant(s) may fail.
4. I have been informed of other methods of treatment or no treatment at all, and the risks of those choices have been presented to me.
5. My doctor has explained to me that there are certain risks and side effects of any surgical procedure including, but are not limited to:
 - A. Post-operative discomfort and swelling
 - B. Bleeding that may require additional treatment
 - C. Injury or damage to adjacent teeth
 - D. Infection
 - E. Restricted mouth opening and aggravation of TMJ problems
 - F. Injury to nerve branches in the lower jaw resulting in numbness, pain or tingling of the chin, lips cheek, gums or tongue. This numbness or pain may in rare instances be permanent.
 - G. Injury to the sinus of the upper jaw.
 - H. Fracture of the jaw.
 - I. Bone loss around implants.
 - J. Implant or prosthesis fracture, or loss of the implant due to rejection by the body.
6. It has been explained that during the course of surgery unforeseen conditions may be revealed which will necessitate changing of the surgery. I authorize my doctor and his staff to perform such additional procedures where necessary in the exercise of his professional judgement.

Initial: _____

7. **ANESTHESIC RISKS** include: allergic reactions (previously unknown) to any of the medication used. Discomfort, swelling or bruising at the site where the drugs are placed into the vein Nausea and vomiting, although not common, are unfortunate side effects of intravenous anesthesia. Intravenous sedation is a serious medical procedure and carries with it the risk of brain damage, stroke, heart attack or death.
8. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until your are sufficiently recovered to care for yourself.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING.**
 - D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a **small sip of water.**
9. It has been explained to me that surgical result is not guaranteed or warranted. Implants place in grafted bone may have a lower success rate.
10. It has been explained to me that poor oral hygiene usually results in implant loss, and that use of tobacco in any form dramatically decreases implant success.
11. I certify that I have had an opportunity to read and fully understand this document and that all blanks were filled in prior to my signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery. I also state that I speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Witness' Signature

Date

Doctor's Signature

Date

If surgery date is different than date above, I have had the opportunity to again review, discuss, and change this informed consent.

Patient's (or Legal Guardian's) Signature

Date