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IV Sedation, Extractions, Implants
Periodontal surgery, Root Canals and Consulting

AUTHORIZATION AND CONSENT FOR IMPLANT TREATMENT

Patient's Name (Print):_____Date:_____

The following implant procedures has/have been recommended:_____

Teeth Number(s): _____

My doctor has also advised me that certain alternative treatment methods exist, including no treatment

or:_____

_____

Non–treatment risk: if I elect not to have any treatment, I understand that there are certain risks including, but not limited to: My present or a condition will probably worsen in time; swelling; pain; and/or infection.

Treatment risk: I understand that there are risks associated with the proposed treatment including, but not limited to:

- Postoperative discomfort and swelling that may persist for several days.
- Stretching of the corners of the mouth with the resultant cracking and/or bruising.
- Injury to the nerve underlying the teeth resulting in numbness or tingling and of the lips, chin, gums, cheeks, teeth, and/or tongue on the operative side that may persist for several days, weeks, months or in some instances may be permanent.
- Sensitivity to filled/crown teeth that may necessitate additional treatment including root canal therapy.
- Discoloration of the gum tissue.
- Swelling, bruising, and bleeding of the adjacent gum tissue.
- Inability to perfectly matched natural enamel with porcelain fused to metal.
- Other:_____

I understand that for successful implant treatment the work must be completed in a timely manner. I further understand and agree that the Doctor and the dental office are not responsible for lab work not delivered within sixty (60) days from the impression appointment. Due to individual patient differences there exist a risk of failure, relapse, selective retreatment, or worsening of my persistent condition despite the care provided. However, it is a doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have not been given any guarantee or warranty of success for this treatment, and I understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same better or worse after treatment and that ongoing care may be necessary. I understand that to aid in successful treatment and to lessen the dangers of complications, I must meet certain requirements namely, excellent oral hygiene, proper diet with restrictions on certain hard or chewy foods, strictly adherence to instructions about using medications, wearing of appliances and cooperation and keeping appointments. I have provided a complete and accurate statement of my medical history. I have had full opportunity to ask questions about the information on this form and have been given answers that are to my satisfaction.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND FURTHER CERTIFY THAT THE DOCTOR HAS EXPLAINED THE RISKS ASSOCIATED WITH THIS PROCEDURE TO ME. I UNDERSTAND AND EXCEPT THE POTENTIAL RISKS. MY SIGNATURE BELOW SIGNIFIES MY ACKNOWLEDGMENT THAT I BELIEVE THAT I RECEIVED SUFFICIENT INFORMATION TO PROCEED WITH THE RECOMMENDED TREATMENT. I HAVE ELECTED TO TREAT MY CONDITION WITH THE PROPOSED TREATMENT RATHER THAN ANY ALTERNATIVE THERAPIES. ALL THE BLANKS WERE FILLED IN PRIOR TO MY SIGNING. I HEREBY AUTHORIZE AND CONSENT TO HAVE THE IMPLANT TREATMENT.

Patient/Parent or Legal Guardian's Signature	Date
Doctor's Signature	Date
Witness Signature	Date