Festina Lente

Integrative Periodontology and Implant Center

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CONSENT FOR ROOT FORM DENTAL IMPLANTS

_____ I hereby authorize
Patient Name

Sofia Petrov DDS, MSD, and any associates to perform Implant Surgery on

tooth/teeth numbers: _____.

Diagnosis: After a careful oral examination and study of my dental condition, my doctor has advised that my tooth or teeth may be replaced with artificial teeth and supported by an implant.

Recommended Treatment: In order to treat my condition, my doctor has recommended the use of root form dental implants. I understand that the procedure for root form dental implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase where the artificial teeth or tooth crowns are placed.

Surgical Phase of the Procedure: I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will be placed by pushing or threading them into holes that have been drilled into my jawbone. The implants will have to be snugly fitted and held tightly in place during the healing phase.

The soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of four to six months. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase.

I further understand that if during surgery, clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my doctor will make a professional judgment on the management of the situation. The procedure may need to be cancelled or may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw to allow placement, gum closure, and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance or artificial crown can then begin.

Prosthetic Phase of the Procedure: I understand that at this point I will be referred to my dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic device will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.

Expected Benefits: The purpose of a dental implant is to allow me to have more functional artificial teeth or improved appearance. The implants provide support, anchorage, and retention for artificial teeth or crowns.

Principal Risk and Complications: I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may need to be removed. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result for the implant surgery, drugs, and anesthetics. These complications include, but are not limited to, post-surgical infection, bleeding, swelling, and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, corners of mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to teeth, bone fractures, nasal sinus penetrations, or other complications which cannot be determined, and they may be irreversible.

I understand that the design and structure of the artificial tooth appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the appliance, or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the tight adaptation between the implant and the surrounding bone may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

Alternatives to Suggested Treatment: Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures – depending on the circumstances.

However, continued wearing of ill-fitting appliances can result in further damage to the bone and soft tissue of my mouth.

Necessary Follow-Up Care and Self-Care: I understand that it is important for me to continue to see my general dentist or prosthodontist. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my doctor.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed will be successful. Due to individual patient differences, a therapist cannot predict certainty of success. There exist the risks of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants, despite the best care.

Publications of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Patient Consent for Root Form Dental Implants

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask questions I have in connection with the treatment and to discuss my concerns with the doctor. After thorough deliberation, I hereby consent to the performance of dental implants surgery as present to me during consultation and in the treatment, plan presented to me.

I also consent to use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my doctor's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____	_____
Date	Printed Name of Patient, Parent, or Guardian
	_____
	Signature of Patient, Parent, or Guardian
_____	_____
Date	Printed Name of Doctor
	_____
	Signature of Doctor