CONSENT FOR ROOT FORM DENTAL IMPLANTS

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY
UNDERSTAND ITS CONTENTS

Diagnosis – After an oral examination, my dentist, Dr. Brandon Roller, has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant(s).

Recommended Treatment – In order to treat this condition, my dentist has recommended the use of root form implants. I understand that the procedure for root form implants involves placing implants into the jawbone. This procedure has a **surgical phase** followed by a **prosthetic/restorative phase**. There are different costs associated with each phase of treatment.

Surgical Phase of Procedure – I understand sedation may be utilized and a local anesthetic will be administered to me as part of the treatment. My gingival tissue will be reflected allowing access to my mandible and/or maxilla (upper or lower jawbone). Implants will then be placed into the osseous (bone) structure.

The surgical site will then be closed with sutures. Osseointegration (close approximation of the implant to the bone) must proceed for a period of at least four months. I understand that dentures cannot be worn during the first one or two weeks of the osseointegration period. Denture contact could place unacceptable pressure on the new implant and cause failure of the implant to integrate.

I understand that the clinical conditions may prove to be unfavorable for the use of this implant system or prevent the placement of implants. In the event of rejection, my dentist may elect to recover or replace the rejected implant. The procedure may also involve supplemental bone grafts or other types of grafts to build up my jaw and thereby assist future implant placement attempts with additional fees incurred.

Most implants require a second surgical procedure. The gingival tissue is reflected and implant stability is assessed. If osseointegration has been achieved, a healing abutment (tissue contouring device) will be placed. Procedures to create an implant prosthetic appliance may proceed after the successful placement of a healing abutment.

Prosthetic/Restorative Phase of procedure – During this stage, a restorative abutment is secured to the implant with a screw. Impressions are taken, and an implant crown fabricated. I understand that the

restorative abutment is retained with a screw that may loosen or break. For this reason, my implant crown(s) will be seated with the least retentive cement required. In this manner, the implant crown(s) may be removed safely and the restorative abutment screw tightened or replaced whenever necessary. Abutment tightening and crown cementation incur separate additional fees.

Expected Benefits – The purpose of dental implants is to allow me to have more functional artificial teeth. The implant provides support, anchorage, and retention for these teeth. Implants prosthetics may sacrifice esthetic results for prosthetic functionality. Implants prosthetics cannot be expected to reproduce the feel and look of natural teeth. Also, additional gingival grafts may be required to achieve more natural gingival contours when possible and additional fees will be incurred.

Principal Risks and Complications – I understand some patients do not respond successfully to dental implants and in such cases the implant may be lost. Implant surgery may not be successful in providing artificial teeth because each patient's condition is unique. I understand complications may result from the implant surgery, drugs, or anesthetics. These complications include, but are not limited to: post-surgical infection; bleeding; swelling and pain; facial discoloration; nerve damage resulting in transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin, or gum(s); jaw joint injuries or associated muscle spasms; transient but on occasion permanent increased tooth loosening; tooth sensitivity to hot, cold, sweet, or acidic foods; shrinkage of the gums upon healing resulting in elongation of some teeth (long looking teeth) and greater spaces between some teeth; cracking or bruising of the corners of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; and accidental swallowing of foreign material. The exact duration of any complications cannot be determined, and they may be irreversible.

Implant Rejection – Despite enhanced biocompatibility (tolerance of the body to accept foreign material), I understand that a dental implant remains a foreign body. Implant rejection may occur anytime after placement. Implant rejection does not implicate the surgical skill set of the placing dentist. Implant rejection does not implicate the skill set of the restorative dentist. Implant rejection does not entitle the patient to a refund for services provided.

[ ]
Initial

Likelihood of Success of the above Procedure(s): ☐Good ☐Fair ☐Poor

Alternatives to Implant Placement – Alternative treatment for missing teeth include no treatment, new removable denture appliances, and fixed appliances. However, missing teeth and continued use of ill-fitting appliances can result in further damage to bone and soft tissues of the mouth.

Necessary Follow up Care and Self Care – I understand that I must regularly visit my dentist for dental cleanings and maintenance. Implants and appliances must be examined periodically and may need to be adjusted. I will follow all prescriptions, post operative instructions, and home care instructions.

Publication of Records – I authorize photos, slides, radiographs (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 reimbursement purposes. My identity will not be revealed to the general public, however, without my written permission.

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

PATIENT CONSENT

I have been fully informed of my diagnosis, the nature of dental root form implant surgery, the purpose of the procedure(s) to be utilized, the prognosis of the procedure(s), the risks and benefits of oral/periodontal surgery, the alternative treatments available, and the necessity for follow up care and self-care. I have had an opportunity to ask questions concerning treatment and to discuss my concerns with my dentist. My dentist has used general terms that I understand to describe the procedures. After thorough deliberation, I hereby consent to dental implant surgery as described in this document.

I also consent to the use of an alternative implant system or method if clinical conditions are found to be unfavorable for the originally selected implant system. If clinical conditions prevent the placement of implants, I defer to my dentist's judgment on the surgical management of the 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, closure, and security of my implants.

"I certify that I have had the 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 stricken before I signed. I also state that I read and write English."

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Roller, and any other doctor or medical-dental personnel who may be involved in the course of my treatment.

Signed on this _____day of _____, 2_____

_____
Patient, Parent or Guardian

_____
Witness

_____
Dr. Brandon Roller