MILLENNIUM PERIODONTICS CONSENT FORM FOR ROOT FORM DENTAL IMPLANTS

Patient_____ Date _____ BP_____ PULSE _____

DIAGNOSIS. After a careful oral examination and study of my dental condition, my periodontist Dr. Christine Gadia or Dr. Robert Busan has advised me that my missing tooth or teeth may be replace with an artificial tooth or teeth supported by an implant.

RECOMMENDED TREATMENT. In order to treat my condition, my periodontist has recommended the use of root form dental 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 phase where the artificial teeth or tooth crowns are placed.

SURGICAL PHASE OF PROCEDURE. I understand anesthetic and/or medication 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 and held tightly in placed during the healing phase.

I understand that in addition to the dental implant, bone grafting as well as maxillary sinus augmentation procedures may be necessary and performed in order to gain adequate bone prior to or during implant placement. I understand that graft materials of various types may be used and may include my own bone, bone obtained from tissue banks (allograft), bone or bovine (calf) origin (xenograft), or synthetic bone substitutes. Membranes, resorbable, or non-resorbable, may be used during the procedure.

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 healing phase.

I further understand that if during surgery, clinical conditions turn out to be unfavorable and prevent the placement of implants; my periodontist 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 and attachment will be connected to the implant. Plans and procedure to create an implant prosthetic appliance or artificial crown can then begin.

PROSTHETIC PHASE OF PROCEDURE. I understand that at this point I will be referred back to my dentist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, and implant prosthetic devise 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 dental implants 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 RISKS AND COMPLICATIONS. Any surgical interference carries certain risks and complications that may arise. I understand that some patients do not respond successfully to dental implants and in such cases, the implant my bleed to be removed or repaired. Implant surgery may not be successful in providing that complications may result from the patient's condition is unique, long-term success may not occur. I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to , post-surgical infections, bleeding or hematoma (blood clot), separation of the wound, extrusion of the bone grafts material and/or membrane, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, 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, injury to teeth, bone fracture, nasal sinus penetrations, delayed healing and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

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PATIENT SIGNATURE **DATE**

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 this 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, a removable appliance, and other procedures – depending on the circumstances. However, continued wearing of ill-fitting appliances can result in further damage to the cone and soft tissue of my mouth.

NECESARRY FOLLOW-UP AND SELF CARE. I understand that it is important for me to continue to see my general dentist. Implants, natural teeth, and appliances must be maintained daily in a clean, hygienic manner. 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 periodontist.

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 therapist 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 or implants, despite the best of care.

PATIENT CONSENT

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of root form implant surgery, and any other course of treatment, as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I also consent to use of an alternative implant system or method if clinical conditions prevent the placement of implants, I defer to my periodontist' judgment on the surgical management of that situation. I also give my permission to receive supplement bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in the placement and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ _____

Signature of Patient, Parent*, or Guardian* **Date**

_____ _____

Signature of Witness **Date**

***IN CASE OF SIGNATURE OF PARENT OR GUARDIAN: BY SIGNING THIS FORM AND CONSNET, PARETN OR GUARDIAN OF A PATIENT REPRESENTS AND AFFIRMS THAT HE OR SHE HAS THE LEAGAL AUTHORITY TO SIGN FOR AND ON BEHALF OF SUCH PATIENT.**

FOR PRE-SURGERY MEDICATION:

1ST DOES TAKEN BEFORE BED TIME: _____ ***TIME***

_____ ***PATIENT'S INITIALS***

2ND DOSE TAKEN 1 HOUR BEFORE SURGERY: _____ ***TIME***

_____ ***DRIVER OF THE PATIENT'S INITIALS***

*****PLEASE BRING THE THIRD DOSE WITH YOU TO YOUR SURGERY******