Shelton DENTAL CENTER

Consent for Dental Implants

Patient Name: _____ **Date**: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your dentist can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form will acknowledge your consent to treatment recommended by your dentist.

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1. I request and authorize Shelton Dental Center to perform the surgical placement of dental implants upon me. This has been recommended to me by my dentist as an option to replace my natural teeth. Dental implants are metal anchors put inside the jawbone underneath the gumline. Small posts are attached to the implants, and artificial teeth or dentures are fastened to the posts.

Most patients need **two** surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. A temporary denture may be worn for a few months while the anchors bond with the jawbone and the gums and bone heal. The second procedure will uncover the implants to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of a fixed or removable bridgework or denture, are fastened to the posts. Depending upon the condition of the mouth, bone grafting or guided tissue regeneration may also be necessary to install the anchors and posts.

The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures.

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications.

3. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs like the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.

4. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following:

- Postoperative discomfort and swelling
- Bleeding
- Postoperative infection
- Injury or damage to adjacent teeth or roots of the teeth
- Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums or tongue
- Restricted ability to open the mouth due to swelling and muscle soreness or stress on the joints of the jaw (temperomandibular joint)
- Fracture of the jaw
- Bone loss of the jaw
- Penetration into the sinus cavity
- Mechanical failure of the anchor, posts or attached teeth
- Failure of the implant itself
- Allergic or adverse reaction to any medications.

Most of these risks, complications and side effects are not serious or do not happen frequently. But although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects. These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization, or blood transfusions. Very rarely, the potential risks and complications could result in permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment or procedures as required.

I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Please do not hesitate to ask the doctor or the staff if you have any questions. Shelton Dental Center 360-GO-BRUSH.

Patient, parent or guardian: _____

Doctor: _____ **Date:** _____