Desert Valley
ORAL SURGERY
Consent for Dental Implant

We believe it its important that you be given information about your planned treatment and obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of the treatment, the known risks associated with the treatment and the feasible treatment alternatives; that you have been given an opportunity to ask questions and that your questions have been answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to further explain.

Nature and Purpose of the procedure - I understand incision(s) will be made inside my mouth for the purpose of placing one or more metallic implants in my jaw(s) to serve as and anchor(s) for a missing tooth or teeth or to stabilize a denture or bridge. I acknowledge that Dr. Hansen has explained the procedure in detail, including the location of the incision(s) to be made. I Understand that the crown (cap), denture or bridge will later be attached to this implant by a general dentist or prosthodontist, and the cost for the work is not included in the charge for this procedure. I have been informed that the implant may remain covered under the gum tissue for up to six months before it can be used, and that a second surgical procedure may be required to uncover the top of the implant.

Alternative to Suggested Treatment - The alternative to a dental implant include: no treatment at all; construction of a standard dental prothesis; augmentation of the upper or lower jaw by means of vestibuloplasty, skin or bone grafting. These alternatives have been explained to me, as have the advantages and disadvantages of each procedure, and I choose to proceed with insertion of dental implant(s).

Authorization for Supplemental Treatment - I understand that during and following the contemplated procedure, conditions may become apparent which warrant, in the judgment of my surgeon, additional or alternative treatment, and I therefore authorize such treatment modifications or alternatives as may become necessary in the judgment of my surgeon. This may include the performance of necessary laboratory, radiological (X-Ray) and other diagnostic procedures; the administration of medications orally or by injection. the removal of bone or soft tissue for diagnostic and therapeutic c purposes, and the retention or disposal of same in accordance with usual practices; the placement of bone grafts and resorbable membranes if the implants remain partially exposed during the placement. A soft tissue graft may also be indicated to the augment the gingiva and help prevent recession and exposure of implant
threads.

Risks of the proposed treatment: Please initial each paragraph after you read and understand the complications known to be associated with this procedure and with anesthesia.

Potential complications include, but are not limited to:

_____ Swelling, damage to ad possible loss of other teeth, fillings or other dental work

_____ Infection, anesthesia rash

_____ Allergic reactions to the medications or materials used

_____ Bleeding which may be prolonged

_____ Nasal problems and infections

_____ Loss of bone or fracture of the jaw

_____ Injury to nerve near the treatment site which may cause pain, numbness or tingling of the lips, chin, face, mouth, teeth and tongue, which is rare, is usually temporary, but in rare cases could be permanent

_____ Loss of or damage to the ability to taste or impaired tongue function

_____ Stretching of the corners of the mouth with resultant cracking and bruising

_____ Opening of the normal sinus cavity located above the upper teeth, which may lead to sinus complications requiring surgery

_____ If bone and membrane are used: additional complications may include exposure of membrane.

_____ If soft tissue graft is used (connective tissue from the root of your mouth) there may be localized altered sensation

_____ Treatment complications may necessitate additional medical, dental or surgical treatment; and may require an additional period of recuperation at home or in the hospital.

_____ I have been told that this treatment may not be successful, that problems may arise during the procedure, which may prevent placement of the implant, and that loosening and rejection of this implant is rare, but possible.

No guarantee of Treatment Results- I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I understand that complications, though uncommon, do occur with any type of surgery.

I _____, hereby authorize Dr. Hansen and associates to perform the following procedure(s):

_____

Signature: _____Date_____

Relationship to Patient: _____