Westhill Dental Clinic

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IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I had all my questions answered by Dr. Broderick in a satisfactory manner.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained including a denture solution and a bridge solution. An additional alternative is to have nothing done. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

3. It has been explained to me that although implants enjoy an extremely high long term success rate, they are not 100% successful and that there is no method to predict healing capabilities in each patient. I understand that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth, and whether the restoration(s) will be permanently fixed to the implants or will be removable by me. I also understand that smoking may decrease the chances of implant success and that I must follow the home care instructions I am given at each stage of the treatment.

4. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, discoloration; injury to the teeth present; jaw joint injury and ongoing risk of jaw fracture after final restorations are placed in very thin jaws or loss of one or more implants. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determined and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc. I also understand that my body may react adversely to the stress of a surgical procedure, with cardiac arrest being the most serious, but remote, possibility.

5. I understand that prosthodontic risks include, but are not limited to, failure of an implant (may be immediate or delayed), fracture of the restoration(s) and/or implant components, wear of the restoration requiring remake, difficulties with speech and/or chewing, compromised esthetic or functional outcome as a result of implant loss or less than ideal angulation or position of the implant(s). Unusual angulation or positioning of the implants may necessitate either more complex and therefore more expensive prosthodontic treatment, than what has been planned or possibly, result in one or more of the implants not being used to retain the prosthesis.
   I understand that failing implants would require surgical removal and may require additional prosthodontic procedures or the subsequent placement of additional implant(s)

6. I consent to the administration of anesthetics or sedative drugs if prescribed and agree not to operate a motor vehicle or hazardous device for at least 24 hours after their administration.

7. I have been informed and I understand that the risks of <u>no</u> treatment include, but are not limited to, continuing use of removable complete or partial dentures with associated potential for discomfort and <u>shrinkage of the jawbones</u> which would necessitate periodic relining or remaking of the denture(s); periodontal disease and/or infection which could lead to the loss of teeth if not treated; and tooth decay, which could also lead to the loss of teeth if not treated.

8. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.

Patients' Initials: _____ ***Doctors' Initials:*** _____

9. It has been explained that in some instances that implants fail and must be removed. I have been informed and understand that because the success of the practice of dentistry is closely linked to the biology of the individual human being, no guarantees or assurances can be made as to the results of treatment or surgery. No guarantee or warranty has been made to me that the proposed implant treatment will be 100% successful or that the final restoration(s) will be totally successful from a functional or appearance standpoint.

10. I understand that, in the event the implant fails it will be removed through a second surgical procedure. Provided I have attended for prescribed follow-up appointments and followed the home care instructions given to me following placement of implants, any re-treatment which is considered appropriate by Dr. Broderick due to implant failure <u>within 1 year of placement</u> will be handled as follows:
    I understand that there will be no refund of the fees in the event of failure.
    I also understand that I will not be charged for clinical services to replace the same number of implants. I will pay for components and laboratory costs and I will be given an estimate of the anticipated charges before retreatment begins. I understand that this does not constitute a warranty but rather a statement of services, and that failure to attend prescribed follow-up appointments or to follow home care instructions following placement of the implant prosthesis means that I will assume all costs for any retreatment required. I will also assume all costs for any necessary retreatment due to implant or prosthodontic failure that occurs beyond this initial 1 year period. I further understand that this statement of services applies only to treatment provided in the Westhill Dental Clinic and does not apply should I pursue surgical treatment elsewhere.
11. I understand that Dr. Broderick is responsible only for the surgical insertion of the implants. I understand that Dr. Broderick or another dentist will make the prosthetic construction. I also understand and agree that I must return for appropriate post-operative care and evaluation, as outlined by my doctor. In addition, once the prosthesis has been completed, I understand that I must return for follow-up implant care at an interval determined by Dr. Broderick for evaluation of the health of the implants, a review of oral hygiene and for plaque removal. A fee will be charged for this service.
12. I understand that smoking and alcohol may affect the healing and the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations and radiographs as instructed.

13. To my knowledge I have given an accurate report of my physical and mental health history. I have reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, and also reported any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

14. I had the opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby consent and request that my doctor proceeds with the surgical and/or restorative procedures for placing and/or restoring my implant(s). I also understand that following the contemplated procedure, surgery or treatment, unforeseen circumstances may necessitate a change in the desired procedure or in the rare cases, prevent completion of the planned procedure.
15. I hereby state that I read, speak and understand English.
16. I consent to photographic recording/documentation of any aspect of my treatment or follow-up care and i understand that these records will be used to document the progress of my care along with other purposes as stated above

_____	_____	_____
Signature of Patient (parent or legal guardian)	(**PRINT NAME**)	Date

_____	_____	_____
Signature of Witness	Signature of Doctor	Date