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CONSENT FOR IMPLANT REMOVAL

Diagnosis, Implant Removal:
After a careful oral examination, radiographic evaluation and study of my dental condition, my doctor has advised me that I may have one or all of the following Implant failure, more than 50% of bone loss around implant, implant fracture, infection and/or an abscess, irretrievable prosthetic complications, malocclusion or malposition of the implant which is preventing the restoration of some other dentition.

Recommended Treatment:
In order to treat my condition, my doctor has recommended the removal of my dental implant (s). I understand that the procedure involves removing the implant (s) from the jaw bone or sinuses. I understand that a local anesthetic will be administered to me as part of the treatment and sedation may be utilized.

Surgical Phase:
My gum tissue will be reflected to expose the bone. Implants will be removed from my jawbone. There is a potential risk of jaw bone fracture with this type of procedure. The soft tissue will be stitched closed over or around the surgical area. Healing will be allowed to proceed for a period of 4 to 6 months or possibly more. I understand that during surgery, clinical conditions turn out to be unfavorable for the replacements of implants. My doctor will make a professional judgment on the management of the situation. The procedure may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw lo facilitate the replacement of the implants.

Alternatives to Suggested Treatment: I understand that alternatives to this procedure include: no treatment. However, continued wearing of ill-fitting appliances and or not treating recurring infections can result in further damage to the bone and soft tissue of the mouth.

Primary Risks and Complications: Sometimes complications may result from the removal of implant(s), or from anesthetics or drugs. There are certain inherent risks in any treatment plan or procedure, and in this specific instance such operative risks include but are not limited to, post-operative discomfort and swelling for one or several days or weeks, heavy bleeding, injury to adjacent tissue, teeth, fillings, caps or other dental work, post-operative infection requiring additional treatment, stretching, cracking or bruising of the corners of the mouth, restricted mouth opening for several days or weeks, decision to leave a small piece of hardware in the jaw when its removal would require extensive surgery, that may require removal at a later time, breakage of the jaw, injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and or tongue on operated side for several weeks, months and on rare occasion permanently, opening of the sinus requiring additional surgery and referral to ENT doctor, future orthodontic treatment of one or all of my teeth, mal-union, fibrous-union, and/or non-union of fracture sites, and a need for additional surgeries/procedures, and dry socket. Depends on existing bone loss, it is possible future implant re-placement not possible, which may lead to alternative treatment for replacing missing teeth, including bridges or removable denture

I understand that if I smoke, I have more risk for the above complications. The exact duration of any complication(s) cannot be determined, and they may be irreversible. There is no method that

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will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

To my knowledge, I have reported to my surgeon any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which may in any way relate to this surgical procedure.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist for routine dental care and get the missing implant replaced as recommended.

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 care.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

I further consent to the examination, testing and/or disposal of any parts or tissue which may be removed, in such a manner as may be determined by the dentist.

Communication with my Insurance Company: My Dentist or other Dental/Medical Providers involved with my care: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Patient or Guardian Signature | Patient or Guardian Print Name | Date

Dentist Signature | Print Name | Date