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COSNENT FOR IMPLANT REPAIR

I am informed and I understand the purpose and nature of implant surgery. I understand what is necessary to accomplish the repair of the implant(s) under the gum and in the bone. I hereby Authorize my dentist in specialty dentistry to perform all procedures which are included in the course of implant therapy upon myself/the patient.

My doctor carefully examined my mouth. The nature of treatment, the benefits, possible risks/complications, and alternatives has been explained. I have tried or considered these methods, but I desire to repair my implant(s) to help keep secure the replaced missing teeth. I am aware that there is a possibility the implant may be too damaged and beyond repair, and the doctor may not be able to save it. I understand the explanation provided and give this consent voluntarily.

Bone Graft Materials: If bone graft around implant is needed, the sources of bone graft materials are from one of following source: your own bone, synthetic bone substitutes, and human donors and/or from bovine (*cow*) or porcine (*pig*) processed in accordance with FDA regulations through FDA approved commercial bone banks/processors. Sometimes sterile, medical grade calcium sulfate (*plaster*) is mixed with the bone. Plaster is inserted and resorbs completely in eight weeks; this is a good source of extra calcium content for obtaining a successful bone graft. A covering may be placed over the bone graft, either a non-resorbable synthetic (*needs to be removed, commonly called a PTFE membrane*), or a medical grade, resorbable sterile collagen (*commonly called collagen barrier*) in a wafer form derived from either bovine (*cow*) or porcine (*pig*) achilleas tendon may be used, depending on the type of bone defect present. The purpose of the barrier is to keep the bone graft material in place. Membranes tend to hold the bone graft material in place while it heals. My gum will be sutured (stitched) back into position over the above-mentioned materials. I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan.

Principal Risks and Complications: I understand some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function or allowing a dental implant to be placed. Because each patient's condition is unique, long term success may not occur. Complications that may result from surgery could involve the bone regenerative materials, drugs, or anesthetics. These complications include but are not limited to, post-operative infection, bleeding. swelling, pain, bruising, numbness of the jaw, lip, tongue, chin or gum, jaw joint injuries or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, transient (*on rare occasion permanent*) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. The exact duration of any complication cannot be determined, and they may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. There may be a need for a second surgery if the initial results are not satisfactory. In addition, the success of oral surgery and dental implant procedures can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Periodontist/Oral Surgeon any prior drug reaction, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I fully understand that my diligence in providing the personal daily care recommended by my Periodontist/Oral Surgeon and taking all medications prescribed are imperative to the success of the procedure.

I understand that, if nothing is done, any of the following could occur: bone disease, continue loss or shrinkage of bone and/or gum tissue, gum tissue inflammation, infection, sensitivity, mobility of implant, or loss of implant. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

My doctor has explained that there is no method to accurately predict the gum and bone healing capabilities

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in each patient following the treatment of an implant. It has been explained that, even though all steps are taken to insure proper healing, some implants fail and must be removed later.

I agree to follow ALL my doctor's home care instructions - including, but not limited to, wearing a Nightguard to report to her any irregularities in healing, and to return for regular examinations and/or treatment as instructed.

- I understand that smoking will adversely affect the gum and bone healing, and may cause failure of the implant to fuse with my bone.
- I understand that chewing on the implant site may prevent proper healing bone and may result in implant failure.

I authorize the administration of anesthetics determined to be necessary and/or advisable by my doctor who is responsible for administering and/or for supervising the administration of anesthetics. In this regard, I have been fully advised as to the nature and purpose of the anesthesia, and the possible risks and complications. I agree to the type of anesthesia, depending on the choice of the doctor. I have abided by all of the preoperative instructions. If IV sedation is used, I agree not to operate a motor vehicle or hazardous device for at least 18-24 hours or more until fully recovered from the effects of anesthesia or drugs given for my care.

I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during an following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve: my modification in design, materials or care if it is felt that this is for my best interest.

To my knowledge, I have given an accurate report of my physical/mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions abnormal bleeding, or any other conditions related to my health. I agree to report any use of recreational drugs. I understand that the use of Bisphosphonates may adversely affect healing of the implant.

I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome or results of treatment or surgery can be made.

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provide my identity is not revealed.

I acknowledge that I have read this document in its entirety and that I fully understand it.

Patient or Guardian Signature | Patient or Guardian Name | Date

Dentist Signature | Print Name | Date