Purdy's Wharf Dental Group

Dental Implant Consent Form

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum and in the bone.
2. Dr. Thistle has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but desire an implant to help secure the replaced missing teeth.
3. I understand that the purpose of the dental implant is to provide support for dental prosthetic reconstruction in the form of a single tooth, bridge or denture to provide orthodontic anchorage.
4. I have further been informed of the possible risks and complications involved with implant surgery, drugs and anaesthesia. Such complications include pain, swelling, infection, nerve damage and discolouration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein or soft tissue, injury to existing teeth, bone fractures, bone loss, sinus penetration, delayed healing, accidental swallowing of foreign matter and allergic reactions to drugs or medication used.
5. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, and looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.
6. Dr. Thistle has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of the implant.
7. It has been explained that in some instances, implants fail and must be removed. The restoration and/or implant components may fracture require remake or repair. Compromised functional or esthetic outcomes can occur because of implant loss or less than ideal angulation or position of the implant(s). I have been informed and understand that the practice of dentistry is not an exact science; no guarantee or assurance as to the outcome of results of treatment or surgery can be made.
8. I understand that excessive smoking, alcohol or sugar may affect gum healing and may limit the success of the implant. I agree to follow Dr. Thistle's home care instructions. I agree to report to Dr. Thistle for regular examinations as instructed.
9. It has been explained to me that once the implant is inserted, the entire dental treatment plan must be completed on schedule or the implant may fail.
10. I agree to the type of anesthesia that Dr. Corbett recommends. Depending on the type of anesthetic, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until I am fully recovered from the effects of the anesthesia or drugs given for my care.

12. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergy or unusual reactions to drugs, foods, insect bites, anesthetics, pollen dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
13. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
14. I hereby consent to, and request that Dr. Corbett place dental implants in my mouth for the purpose of dental restorations.

Patient.s Signature: _____Date: _____

Doctor.s Signature: _____Date: _____

Witness. Signature: _____Date: _____