ORAL & MAXILLOFACIAL SURGERY
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CONSENT FOR TWO-STAGE OSSEOUS INTEGRATED IMPLANT SURGERY

You have the right to be given pertinent information about your proposed implant placement so that you have sufficient information to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is confirmation that we have discussed the nature of the proposed treatment, the known risks associated with it and the feasible alternative treatments.

PATIENT:_____DATE:_____

I hereby authorize **Dr. Amin**, and any other agents, assistants or employees selected by him to treat the condition described as:

_____
_____
_____

The procedure necessary to treat the condition has been explained to me, and I understand the nature of the procedure to be:

_____
_____
_____

I understand incisions will be made inside my mouth for the purpose of placing one or more endosteal root form structures (implant) in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that a crown, bridge or denture will later be attached to the implant(s).

I understand that the implant must remain covered by gum tissue for at least three (3) months before it can be used and that a second procedure is required to uncover the top of the implant. No guarantee can be or has been given that the implant(s) will last for a specific time period. I also understand that there will be no refund of the fees in the event of failure. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this is not carried out,
the implant(s) may fail.

I have been informed of possible alternative methods of treatment (if any) including:_____
_____
_____

I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

A) Post-operative discomfort and swelling that may require several days of at home recuperation.
B) Prolonged or heavy bleeding that may require additional treatment.
C) Injury or damage to adjacent teeth or roots of adjacent teeth.
D) Post-operative infection that may require additional treatment.
E) Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.
F) Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
G) Injury to the nerve branches in the lower jaw resulting in numbness or tingling of the chin, lips, cheek, gums, or tongue on the operated side, or in rare instances permanently.
H) Opening of the sinus (a normal chamber above the upper back teeth) requiring additional treatment.
I) If the sinus is intentionally entered (sinus lift procedure with grafting), there will usually be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
J) Fracture of the jaw.
K) Other:_____
_____
_____

It has been explained to me that during the course of the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure of a different procedure from those set forth in the paragraph above. I authorize my doctor and his staff to perform such procedure as necessary and desirable in the exercise of professional judgment.

I consent to the administration of general/nitrous oxide/local anesthesia in connection with the procedure referred to above. If intravenous (general) anesthesia is used, there may be soreness at the injection site or along the vein, as well as some bruising around the injection site. In rare cases, the vein irritation may cause restricted mobility of the arm or hand and may require additional treatment.

I have been made aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, incoordination and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.

I understand that I am not to have **ANYTHING** (or have not had anything) for at least 6 hours before my surgery.
TO DO OTHERWISE WOULD BE LIFE THREATENING.

It has been explained to me and I understand, that a perfect result is not and cannot be guaranteed or warranted.

I certify that I speak, read, and write English and have read and fully understand this consent for surgery;
and that all appropriate blanks were filled in prior to my initiating and signing this form.

PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

_____

Patient's or legal guardian's signature **Date**

_____

Witness' signature **Date**

_____

Doctor's signature **Date**