# MONESMITH & WOOD
## ORAL & MAXILLOFACIAL SURGERY, P.C.

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## CONSENT FOR OSSEOINTEGRATED 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 the surgery. What you are being asked to sign is a confirmation that we have discussed the nature of the proposed treatment, the known risks associated with it, and the feasible alternative treatments.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE SIGNING THE CONSENT.

**Patient Name** _____ **Date**_____

After a careful examination, my doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant or implants.

In order to treat my condition, my doctor has recommended the use of root form dental implants. I understand that incisions will be made inside my mouth for the purpose of placing one or more root form implants 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 my doctor has explained the procedure, including the number and location of implants(s) to be used. I understand that the crown, bridge, or denture, that will be attached to this implant will be made by my restorative dentist or prosthodontist and that a separate fee will be charged for that work. I understand that the implant(s) must heal for four to six months before it can be used. For implants covered by gum, a second procedure is required to uncover them.

No guarantee can be or has been given to me that the implant(s) will last for a specific time period. 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 schedule is not carried our, the implant(s) may fail.

I have been informed of possible alternative to treatment. These include: no treatment, a bridge, new removable appliance(s), or possible other surgical procedures - depending on the circumstances. I understand that the continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissues of my mouth.

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. Postoperative discomfort and swelling that may require several days of recuperation.
b. Prolonged bleeding that may require additional treatment.
c. Injury or damage to adjacent teeth or roots of adjacent teeth.
d. Postoperative 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; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened.
g. Injury to the nerve branches in the jaws resulting in numbness or tingling of the chin, lips, cheek, gums, or tongue on the operated side. This may persist for several weeks, months, or in rare instances, permanently. Dysesthesia (numbness that is painful) is also possible. In some cases the implant(s) may need to be removed.
h. Opening into 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 may be associated sinusitis symptoms, requiring medications, additional surgery, or additional recovery time.
j. The removal of grafting bone from any donor site has potential risks and complications, which have been explained to me.
k. Fracture of the jaw.

It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitate extension of the original procedure or a different procedure from that which was planned. In rare cases it may not be possible to continue with the procedure. I authorize Drs. Monesmith & Wood and their staff to perform such procedure(s) that are necessary and desirable in the exercise of professional judgment. I hereby authorize Drs. Monesmith & Wood and their staff to perform the following procedure(s): _____

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I understand that it is important for me to continue to see my doctor. Implants, natural teeth, and prostheses have to be maintained in a clean, hygienic manner. Implants and prostheses must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given me by my treating doctor(s).

I consent to the administration of the following anesthesia:

LOCAL NITROUS OXIDE IV SEDATION GENERAL ANESTHESIA

If intravenous or general anesthesia is used, there may be inflammation and/or bruising at the injection site (phlebitis), sometimes restricting mobility of the arm or hand and may require additional treatment. Rare complications include allergic or unexpected drug reactions, or other life threatening conditions. **IF I AM TO HAVE INTRAVENOUS SEDATION OR GENERAL ANESTHESIA, I UNDERSTAND THAT I AM TO HAVE <u>NO FOOD OR DRINK FOR SIX HOURS</u> BEFORE MY APPOINTMENT. TO DO OTHERWISE MAY BE LIFE THREATENING.**

I have been made aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, lack of coordination and awareness. The use of alcohol and other drugs can increase the effects of these 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 the same. I understand that 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 accompany me until I am fully recovered from the effects of the sedation. **I ALSO UNDERSTAND THAT IF I AM GIVEN AN IV SEDATION, THERE IS NO GUARANTEE THAT I WILL BE COMPLETELY ASLEEP DURING MY PROCEDURE. I UNDERSTAND THAT IN SOME INSTANCES, PATIENTS UNDERGOING SURGERY UNDER IV SEDATION CAN REMEMBER PORTIONS OR POSSIBLY ALL OF THE PROCEDURE, INCLUDING SOME PAIN.**

I have had an opportunity to discuss my past medical history with my doctor, including psychological disorders, drug use, medications I am taking, or other problems which may affect my anesthesia or surgery. I have truthfully revealed all aspects of my health history. It has been explained to me that if I am taking birth control pills that additional, alternative methods of birth control will be necessary while taking any drugs prescribed by this office <u>for my entire cycle.</u>

I understand that although good results are expected, the nature of all possible complications and individual patient differences cannot be accurately anticipated and therefore 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 both pages of this consent for surgery and that all blanks were filled in prior to my signing this form. I have discussed the preceding with my doctor and all my questions have been answered to my satisfaction and I have made a voluntary choice to proceed with the proposed surgery.