CONSENT FOR DENTAL IMPLANT SURGERY

Patient's Name: _____ Date: _____

Your Diagnosis is: _____

Your Planned Treatment is: _____

Please initial each paragraph after reading, but please ask any questions BEFORE initialing.

_____ 1) I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by Dr. Eddleman. He has carefully examined my mouth and informed of the alternatives to implant surgery for replacement of my missing teeth, including, but not limited to, removable partial denture, bridge, and space maintainer. I have considered these alternatives, but I desire the plan my dentist and I have discussed.

_____ 2) I understand that if no treatment is elected to replace the missing teeth or existing dentures, the non-treatment risks include, but are not limited to: maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but likely, progressive dissolution of the underlying denture-supporting jaw bone; any present discomfort or chewing inefficiency with the existing partial or full denture(s) may persist or worsen in time; drifting, tilting, and/or extrusion of remaining teeth; sensitivity and looseness of teeth, followed by the possible necessity of extraction; potential temporomandibular joint problems with headaches, referred pains of the back of the neck and facial muscles, and tired muscles when chewing, caused by a deficient, collapsed or otherwise improper bite.

_____ 3) I understand that incisions will be made in my gums and holes made in my jawbone to put in one or more dental implants. They will be the base for replacement of one or more missing teeth or to hold a crown (cap), bridge or denture (plate). If a crown, bridge or denture is to be attached to the implant(s), Dr. Eddleman will do this as a separate procedure and fee. On occasion, freeze-dried demineralized donated bone is used to supplement the patient's bone, or to spare an extensive donor site surgical procedure. Use of such bone may involve separate risks including, but not limited to: rejection of the donated graft material together with the entire graft. I may need additional procedures to uncover the top of the implant, trim the gum tissue, or to add bone or gum tissue. I have been told that once the implant is put in, I need to follow through with the whole treatment plan and finish it in the timeframe suggested. If this is not done, the implant(s) may prematurely fail. I understand the procedures that are necessary to accomplish the placement of implant(s) in my mouth.

_____ 4) I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post-surgical dental procedures. I am further aware that there is a risk that the implant may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed. I understand that implant success is dependent upon a number of variables including, but not limited to: individual patient tolerance and health, anatomical variations, patient home care of the implant, and the implant material and design. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist. I have been informed of the possible risks and complications of implant surgery, anesthesia, and the proposed procedures including, but not limited to: failure of the implant(s), inflammation, bruising, swelling, infection,

discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus perforation, cardiac stimulation, muscle soreness, delayed healing or allergic reaction to the medications used. I understand that these complications can occur even if all surgical and dental procedures are done properly. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from the now contemplated treatment, I authorize my dentist to perform what he deems necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure. I approve any modifications in designs, materials, or care, if my dentist, in his professional judgment, decides it is in my best interest to make such modifications. Fortunately, these complications and side effects are not common. All forms of Anesthesia are generally very safe, comfortable, and easy to deal with. If you have any questions, PLEASE ASK.

_____ 5) I have given an accurate report of my health history. I have also reported any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, blood or body disease, gum or skin reactions, abnormal bleeding, or any other condition related to my health or any problems experienced with any prior medical, dental or other health care and treatment. I have been advised that smoking, alcohol or excessive sugar consumption may affect gum healing and may limit the success of the implant(s). Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions. I realize that postoperative care and maintenance treatment is critical for the ultimate success of the dental implant(s). I further realize that to maintain my implants, routine dental visits and prophylactic cleanings with my dentist's office are necessary, and that periodic procedures may be required to ensure the success of the implants. I agree that if I do not follow my dentist's recommendations and advice for postoperative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist.

INFORMED CONSENT

Dr. Eddleman and/or his staff have explained to me the fees involved in my treatment. He has also explained my insurance benefits, if any, and I understand that they are based on information supplied by my insurance company, not Dr Eddleman. I agree to pay all fees, or any portion thereof, not covered or even denied by insurance benefits. I have read and understand all of the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form. This consent for treatment shall remain in force for all treatment performed as long as I am a patient of Dr Eddleman, or until I inform their practice in writing that this consent is withdrawn.

Date: _____ Patient Signature: _____

Date: _____ Dentist Signature: _____

Date: _____ Witness Signature: _____