INFORMED CONSENT

Full-Arch Implant Surgery and Prosthesis

All-on-X — fixed or removable implant-supported teeth

Please read this form carefully and ask us about anything that is unclear before you sign.

PATIENT NAME _____ DATE OF BIRTH _____

TREATING DOCTOR _____ DATE OF SURGERY _____

RESTORING DENTIST / LAB _____ REFERRING DENTIST _____

1 Recommended Treatment

I give my consent to the treating doctor named above, and to the dental team working under the doctor's direction, to perform the following procedure(s) on me or my dependent, for the purpose of supporting a fixed and/or removable full-arch dental prosthesis (the "Recommended Treatment"):

ARCH(ES) TO BE TREATED

- ☐ Upper (maxillary)
- ☐ Lower (mandibular)

PLANNED PROCEDURES (DOCTOR TO CHECK THOSE THAT APPLY)

- ☐ Extraction of remaining teeth in the arch(es) and removal of infected tissue
- ☐ Reduction and smoothing of the jawbone (alveoplasty) to create room for the prosthesis
- ☐ Placement of dental implants, which may include angled (tilted) implants
- ☐ Placement of abutments (connectors) on the implants
- ☐ Immediate provisional (temporary) fixed prosthesis, delivered on the day of surgery or shortly after, **if conditions permit**
- ☐ Delayed loading — implants are allowed to heal before a prosthesis is attached
- ☐ Bone grafting at the time of surgery
- ☐ Final fixed prosthesis after healing
- ☐ Other:_____

I also consent to any additional procedure(s) the doctor considers necessary for my well-being based on findings made during the course of the Recommended Treatment, and to the administration of local anesthesia. I will sign a separate consent for any sedation or anesthesia. The nature and purpose of the Recommended Treatment have been explained to me, and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed.

2 What to Expect

Full-arch treatment is done in phases, and the plan may change based on what is found during surgery:

- **Surgery.** Remaining teeth that cannot be kept are removed, the bone may be reshaped, and implants are placed. If the implants are stable enough, a temporary fixed prosthesis may be attached the same day or shortly after.
- **Healing.** The implants need time to fuse with the bone, commonly several months. During this time I will need a soft diet and regular check-ups, and the temporary prosthesis may need adjustment or repair.
- **Final prosthesis.** After healing, the final prosthesis is designed, tried in, and delivered. Its materials, shape, and fit are discussed with me in advance.
- **Lifelong maintenance.** The prosthesis and implants require daily home care and regular professional cleaning and evaluation, and the prosthesis may need periodic removal for cleaning or repair.

Expected benefits may include improved chewing, stability, and appearance compared with a conventional denture. These benefits are not guaranteed, and results vary.

3 Treatment Alternatives

Alternative methods of treatment have been explained to me, including the following (doctor to check those discussed):

☐ **Conventional removable denture(s)**

☐ **Implant-retained overdenture** (removable, attaches to implants)

☐ **Fixed dental bridge** supported by remaining teeth and/or implants

☐ **Other implant procedures,** including a different number or configuration of implants, staged treatment with healing before loading, or zygomatic/pterygoid implants

☐ **Bone and/or tissue grafting** prior to implant placement

☐ **Sinus lift and/or nerve repositioning** procedures

☐ **No further treatment** — continued or worsening dental disease, pain, infection, and bone loss may occur

☐ Other:_____

Having considered these alternatives, I wish to proceed with the Recommended Treatment described above.

4 Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and with performance of the Recommended Treatment. These include, but are not limited to, the following:

SURGICAL AND HEALING RISKS

1. **Drug reactions and side effects.** Including allergic reactions to medications, anesthetics, or antibiotics.
2. **Pain, bleeding, and infection.** Post-operative pain, bleeding, oozing, and soft-tissue and/or bone infection. In rare cases an infection can spread to the face, neck, or other areas and require urgent treatment.

3. **Swelling, bruising, and stiffness.** Bruising and/or swelling of the face, lips, and neck, and restricted mouth opening for several days or weeks, or, rarely, longer.
4. **Delayed healing.** Healing may be slower than expected, including opening of the incision or exposure of bone, necessitating post-operative care and treatment.
5. **Change in plan.** Because of bone quality and/or quantity that could not be assessed with pre-treatment diagnostic tests, a planned implant may not be able to be placed as planned. The number, position, or timing of implants and prosthesis may change, and the temporary prosthesis may be delayed.
6. **Sinus involvement.** Treatment in the upper back (posterior) jaw may involve the sinus and create an opening from the mouth into the nasal or sinus cavity, which may require additional treatment or surgical repair at a later date.
7. **Nerve injury.** Extractions and implant placement, particularly in the lower jaw, may injure nerves, resulting in temporary or permanent tingling, numbness, or pain (possibly of an electric-shock nature) of the lower lip, chin, tongue, or other surrounding structures, with potential alteration or loss of taste.
8. **Jaw fracture and floor-of-mouth bleeding.** A thin or weakened jaw can fracture. In rare cases, bleeding in the floor of the mouth can threaten the airway and require emergency care.
9. **Health and lifestyle factors.** Smoking or vaping, nicotine use, uncontrolled diabetes, a weakened immune system, and certain other conditions or medications increase the risk of infection, delayed healing, and treatment failure.
10. **Medications and prior radiation.** If I take medications that affect bone (such as bisphosphonates or denosumab) or have had radiation therapy to the head or neck for tumors/cancer, I am at higher risk for poor bone healing or bone death (osteonecrosis) that may never completely resolve and may require surgery or other treatment.
11. **Local anesthesia effects.** As a result of the injection or use of local anesthesia, there may be swelling, jaw muscle tenderness, or numbness, tingling, or pain of the tongue, lips, teeth, jaws, and/or facial tissues, and altered or lost taste. This is typically temporary but, in rare instances, may be permanent.
12. **Jaw joint (TMJ) problems.** Pain and/or limited movement of the jaw joint, either temporary or permanent, which may require further treatment.

IMPLANT RISKS

13. **Implant failure.** Non-healing of one or more implants, or later implant loss, necessitating removal and/or other procedures, possibly including bone grafting and/or soft-tissue grafting.
14. **Increased risk in this procedure.** Because of the unique issues associated with the number, angle, and immediate loading of implants in this procedure, there is an increased risk of infection, loss of bone in the jaw, loss of the implants, and loss of the prosthetics placed on them. Failure of the implants may leave me needing a conventional denture or additional surgery.
15. **Bone loss and infection around implants (peri-implantitis)** over time, especially with inadequate hygiene, smoking, or diabetes, which may require treatment, surgery, or implant removal.

PROSTHESIS AND FUNCTION RISKS

16. **Temporary prosthesis.** The temporary prosthesis is not as strong as the final one and may fracture, loosen, or need repair or replacement. If the implants are not stable enough at surgery, an immediate fixed prosthesis may not be possible, and I may need a removable temporary denture or be without teeth for a period.

17. **Final prosthesis.** Teeth or the framework may chip, wear, or fracture, and screws may loosen. Repairs, relines, or replacement may be needed over time, with additional cost. The prosthesis is not guaranteed to last for life.
18. **Speech, appearance, and bite.** My speech (for example, lisping or whistling), lip support, smile, and bite may change and may take time to adapt. The final appearance may differ from my expectations, mock-ups, or photos.
19. **Cleaning and food trapping.** Food may collect under or around the prosthesis. Special cleaning techniques and professional maintenance are required.
20. **Clenching and grinding.** Clenching or grinding increases the risk of fracture and implant complications, and a night guard may be recommended.
21. **Material sensitivity.** Rarely, a person may react to implant or prosthetic materials.
22. **Swallowing or inhaling.** A tooth, tooth fragment, instrument, or small implant component may be swallowed or inhaled and may require retrieval.

5 After Treatment and My Responsibilities

- I will follow all post-operative instructions, including medications, rinses, rest, and a soft or liquid diet, and I will not chew hard or sticky foods until the doctor clears me.
- I will not remove, repair, or alter my fixed temporary prosthesis, and I will call the office if it becomes loose, cracked, or painful.
- I will clean my implants and prosthesis exactly as shown to me and will attend all follow-up and maintenance visits at the intervals the doctor recommends.
- I will avoid smoking, vaping, and nicotine as directed, because they significantly reduce the chance of healing and long-term success.
- I will wear a night guard if one is prescribed.
- I will tell the office about any change in my health or medications, including blood thinners, bone-affecting medications, or diabetes control.
- I will contact the office promptly — or go to the nearest emergency room if I cannot reach the office — for spreading swelling, fever, bleeding that does not stop with pressure, severe pain, pus, or any difficulty breathing or swallowing.

6 Photographs and Records (Optional)

My care may be documented with photographs, X-rays, 3D scans, and clinical notes, which become part of my dental record. In addition, I may choose whether my records can be used for professional education, case presentation, or publication:

☐ I **agree** to the use of my records for education and professional case presentation, with all identifying information removed (no name, date of birth, or other identifiers).

☐ I **do not agree**; my records may be used only for my own care and the operation of this practice.

My choice will not affect my care. I will be asked for separate written permission before any image showing my face or other identifying features is published.

7 Patient Acknowledgment

By signing below, I confirm that:

- The nature and purpose of the Recommended Treatment, its expected benefits and risks, and the alternatives — including no treatment — have been explained to me in terms I understand.
- I have had the opportunity to ask questions, and they have been answered to my satisfaction.
- The health history, medication, and allergy information I have given this office is complete and accurate, and I will report any change before treatment.
- I understand that the risks listed in this form are not a complete list, that no guarantee has been made about the result, and that additional or different treatment may be needed.
- I understand that I may ask questions, or withdraw my consent, at any time before treatment begins.
- I have been offered a copy of this signed form.

I consent to the Recommended Treatment described in this form.

8 Signatures

☐ Interpreter or language assistance used — name / ID:_____

_____ _____

Patient / parent / legal guardian signature | Date and time

_____ _____

Printed name | Relationship to patient (if signer is not the patient)

_____ _____

Witness signature | Witness printed name

Doctor's statement. I have discussed the nature, purpose, benefits, risks, and alternatives of the Recommended Treatment with the patient (or the patient's legal representative), have answered their questions, and believe they understand and consent.

_____ _____

Treating doctor signature | Date and time