INFORMED CONSENT

Implant Placement

Surgical phase — single or multi-stage

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 PROCEDURE _____

RESTORING DENTIST _____ 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 single or multi-stage implant placement procedure(s) on me or my dependent (the "Recommended Treatment"):

- ☐ Single-stage placement (healing component visible through the gum during healing)
- ☐ Two-stage placement (implant covered by gum during healing and uncovered in a later procedure)
- ☐ Immediate placement at the time of tooth extraction
- ☐ Immediate temporary tooth, if conditions permit
- ☐ Other:_____

Implant site(s) / tooth number(s): _____

I understand that the final crown, bridge, or denture will be made and placed by my restoring dentist. 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. If sedation is planned, I will sign a separate sedation consent. 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

After placement, the implant needs time to fuse with the bone (osseointegration), commonly several months, before my restoring dentist can attach the final tooth. A temporary replacement may or may not be possible during healing. Timing varies, and treatment may take longer than planned. Success cannot be guaranteed.

3 Treatment Alternatives

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

- ☐ **No treatment** — the space remains, neighboring teeth may shift, and the bone in the area may shrink over time
- ☐ **Removable partial or complete denture**
- ☐ **Fixed bridge** supported by neighboring teeth
- ☐ **Bone grafting, sinus lift,** or other procedures before implant placement
- ☐ **Other implant types or techniques**
- ☐ 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:

GENERAL 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 and stiffness.** Bruising and/or swelling, and restricted mouth opening for several days or weeks, or, rarely, longer.
4. **Delayed healing.** Healing may be slower than expected, necessitating post-operative care and treatment.
5. **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.
6. **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.

SURGICAL AND IMPLANT RISKS

7. **Inability to place the implant.** Because of bone quality or quantity that could not be assessed with pre-treatment diagnostic tests, a planned implant may not be able to be placed, and treatment may be changed, postponed, or cancelled.
8. **Implant loss.** Loss of the implant and/or of the restorations later supported by it.
9. **Non-healing.** Non-healing of the implant, necessitating its removal and/or other procedures, possibly including bone grafting and/or soft-tissue grafting.
10. **Bone loss and infection around the implant (peri-implantitis)** over time, which may require treatment or removal of the implant.

11. **Damage to neighboring teeth.** Damage to, or fracture of, adjacent teeth, fillings, crowns, or other restorations.
12. **Sinus involvement.** Placing an implant in the upper back (posterior) jaw may involve the sinus, which may require additional treatment or surgical repair at a later date.
13. **Nerve injury.** Placing an implant in the lower jaw may injure the nerves of the lower jaw, 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.
14. **Jaw joint (TMJ) problems.** Pain and/or limited movement of the jaw joint, either temporary or permanent, which may require further treatment.
15. **Gum appearance.** Discoloration and appearance changes of the gum tissue, gum recession, or an unsatisfactory cosmetic result.
16. **Swallowing or inhaling.** A tooth, tooth fragment, instrument, or small implant component may be swallowed or inhaled and may require retrieval.
17. **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.

5 After Treatment and My Responsibilities

- I will follow all post-operative instructions, including medications, diet, rest, and oral hygiene, and will avoid pressure on the implant site during healing.
- I will avoid smoking, vaping, and nicotine as advised, because they reduce the chance of success.
- I will attend all follow-up visits and will see my restoring dentist at the time recommended so that treatment can be completed.
- I will contact the office promptly for swelling that is spreading, fever, pus, bleeding that does not stop with pressure, severe pain, or an implant or healing component that becomes loose.

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