Implant Patient Information and Consent Form

1. I have been informed and I understand the purpose and the nature of the dental implant surgery procedure. I understand what is necessary to accomplish the placement of implant into the bone.
2. Dr. Chu has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire dental implants.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reaction to drugs and medications used, etc.
4. I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, and nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of neck and facial muscles, and tire muscle when chewing.
5. Dr. Chu or his staff has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of implant.
6. It has been explained that, in some instances, implants failed and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantee or assurances as to the outcome of treatment or surgery can be made.
7. I understand that extensive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow Dr. Chu's home care instructions. I agree to report to Dr. Chu for regular examinations as instructed.
8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until recovered from the effect of the anesthesia or drugs given for my care.
9. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, blood or body diseases, gum or skin reaction, abnormal bleeding, or any other conditions related to my health.
10. I consent to photography, filming, recording, and x-rays of the procedures to be performed for the advancement of implant dentistry, provided my identity is not revealed.
11. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if is it felt this is for my best interest.

_____ _____

Signature of Doctor Signature of Patient

_____ If the patient is unable to sign or is a minor (Signature of parent or legal guardian)

_____ _____

Date Relationship to Patient

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