RADFORD
FAMILY DENTAL

1151 E Main Street, Suite A
Radford, VA 24141
Telephone: (540)639-1674

Implant Patient Information & Consent form

An explanation of your need for dental implant(s), their purpose and benefits, the surgeries related to their placement and exposure, and the possible complications as well as alternatives to their use, were discussed with you at your consultation. We obtained your verbal consent to undergo the implant surgical treatment planned for you. Please read this document, which restates issues we discussed, and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

I hereby authorize Dr. Glenn Evans DMD, Dr. Kyle Nield DDS, Dr. Cameron Egan DMD (hereinafter called "Doctor") to perform the following implant surgery upon

_____

(Name of Patient)

To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any pri_____ or allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.

DIAGNOSIS I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone. This is done by first reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone, and covering the bone and Implaimplant with the gum flap.

SURGICAL PROCEDURES I agree to the type of anesthesia:

_____ Local Anesthesia

_____ Nitrous Oxide (may not be covered by insurance)

_____ Valium or Xanax (can not be used in conjunction with Nitrous oxide)

_____ Moderate IV sedation

I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a crown, bridge or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed. I also understand that sometimes the implant(s) is covered with a bone graft material or a membrane to further enhance healing and that this may necessitate an additional procedure to remove the membrane.

ALTERNATIVES My doctor has carefully examined my mouth. Alternatives such as bridge, dentures or no treatment at this time have been explained. I have tried or considered these methods, but I desire an implant to help secure replaced missing teeth.

(Initial here) _____

RISKS

I have further been informed of the possible risks and complications involved with surgery and drugs. Such complications include, but are not limited to, pain, facial discoloration, perforation of the upper jaw sinus or nasal cavity, swelling, infection, muscle spasms, bone fractures, slow healing, temporary or permanent numbness of the lip, tongue, chin, cheek or teeth which may occur. The exact duration of the numbness is unknown and may be irreversible. Possible inflammation of a vein, injury to the teeth or the nerves of the teeth, or an allergic reaction to the drugs and medications used are also possible. Prosthetic risks include, but are not limited to, unsuccessful union of the implant(s) to the jaw bone, and/or stress metal fracture of the implant(s). Risks related to the anesthetics include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness and/or discoloration or blockage along a vein at the injection site.

CONSENT TO UNFORESEEN CONDITIONS DURING SURGERY During treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating doctor. 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 it is felt this is for my best interest.

SUPPLEMENTAL RECORDS AND OBSERVERS In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photography, filming, recording and x-rays being taken of my oral and facial structures, and subsequent publication solely for educational and scientific purposes, and to having health professional observers in the operatory for education purposes. Any images will be taken in such a way as to protect my anonymity. PRE AND POST OPERATIVE INSTRUCTIONS Certain prescribed anti-anxiety medication may cause drowsiness, alone or in combination with alcohol or other sedatives. I (the patient/guardian) have been advised not to drive or operate dangerous machinery within 24 hours of taking such medication. Accordingly, I (patient/guardian) have arranged to be driven and accompanied home by another person.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS I understand that smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and post-operative instructions. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

NO WARRANTY OR GUARANTEE I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). I have been informed and understand the probability of success of this procedure based on scientific data and the surgeon's experiences. It is anticipated that the implant(s) will be permanently retained, but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long-term success cannot be promised. It has

been explained to me that, if the implant fails, it must be removed, and that, if desired, a second implant may be placed.

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(Initial here) _____

It has been explained to me that the long-term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS DOCUMENT AND THE EXPLANATIONS REFERRED TO OR IMPLIED, AND THAT AFTER THOROUGH DELIBERATION, I GIVE MY CONSENT FOR THE PERFORMANCE OF ANY AND ALL PROCEDURES RELATED TO THE PLACEMENT OF DENTAL IMPLANT(S) AS PRESENTED TO ME DURING THE CONSULTATION AND TREATMENT PLAN PRESENTATION BY THE DOCTOR OR AS DESCRIBED IN THIS DOCUMENT.

Patient Name _____ _____

(Please Print) **Signature of Doctor**

Signature (Patient/Parent/Legal Guardian _____

Signature (Witness) _____

_____ _____

Relationship to Patient **Date**