DENTAL IMPLANT CONSENT FORM

Patient: ___________________________________

I herby consent to the surgical placement of dental implants, which will be performed by **Dr. Amir Guorgui**, General Dental Surgeon.

I understand the purpose of the dental implant is to provide support for dental prosthetic reconstruction in the form of single tooth, bridge, or denture, or to provide orthodontic anchorage. At present, we cannot predict the length of time dental implants will provide service in the oral cavity. I know that smoking lowers the chances of implant success in direct proportion to the amount smoked. I understand that in the event the implant fails to integrate, it must be removed through a second surgical procedure, and there can be no refund of all or part of the fee for the lost implant. However, the implant can be replaced, if necessary with no further costs to me, the patient, other than the anesthetic fee incurred. I understand the alterative conventional dental treatment options and I am aware of the consequences of receiving no treatment.

I understand that the implant surgery and prosthetics will be done in the established way and that the risks in the front of the mouth consist of the usual ones associated with simple gum surgery including, but not limited to pain, swelling, bruising, infection and bleeding. Additional complications have been reported for implant surgery in the back of the mouth; they consist of possible permanent numbness of the lower lip on the treated side in the lower jaw, and the creation of a communication between the sinus and the mouth on the treated side in the upper jaw. Both of theses complications would require further surgery for correction.

I agree to make every effort to return for follow-up visits three months, six months, one year, eighteen months and two years after the surgery and to have the needed x-rays taken as well as any cleaning and adjustment procedures needed to keep my mouth healthy at the usual and customary fees, but I am aware that this is entirely voluntary on my part.

Photographs and clinical data might be used in scientific papers and presentations and the confidentiality of the patient will be respected.

I certify that I have read and fully understand the above consent of treatment, and I am fully satisfied with the explanations given to me by Dr. Amir Guorgui

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Patient's or legal guardian's signature   Date

I confirm that I have explained the proposed treatment and potential risks and/or complications associated with the procedure.

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Doctor's signature   Date