AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett

PATIENT'S CONSENT FOR ROOT FORM DENTAL IMPLANTS AND ASSOCIATED PROCEDURES

Diagnosis: My periodontist has advised me that I have missing teeth or hopeless teeth scheduled for extraction.
Recommended Treatment: In order to treat this condition my periodontist has recommended that my treatment include a dental implant(s) and any procedure that might enhance the bone support for the prosthesis. Bone enhancement might include the addition of artificial or tissue bank human or animal substances. The use of artificial or tissue bank human barriers will enhance the proper healing of the implant bony sights. I understand that a local anesthetic and antibiotics and other substances may be applied to the healing sites and/or prescribed systemically.
Surgical Phase of Procedure: During this procedure, my gum will be opened (flapped) to permit access to the bone for the insertion of dental implants and/or bone enhancement materials. Implants will be placed by tapping or threading them into small holes that have been prepared in my jawbone. Bone enhancement materials covered with artificial or tissue bank barriers may be placed over the implant sites and covered with my tissues that will be stitched closed over or around the implants. Healing will be allowed to proceed for a period of up to four or more months. For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time and the stability of the implant verified. If the implant appears satisfactory, an attachment (abutment/healing collar) will be connected to the implant.
Prosthetic Phase of Procedure: I understand that, at this point, I will most likely be referred back to my dentist or to a prosthodontist. During this phase, an implant prosthetic device will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system used.
Expected Benefits: The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage and retention for these teeth.
Principal Risks and Complications: I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long term success may not occur. I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to: post-surgical infection, bleeding, swelling, pain or facial discoloration, transient but occasional permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but occasional permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to teeth, bone fractures, gum disease around implant, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. For patients who are taking or have taken medications (pills or injectable/intravenous) for cancer or osteoporosis such as bisphosphonates (Prolia,Fosamax, Didromel, Boniva, Aredia, Actonel, Skelid, Reclast and Zometa, etc.) there is an increased risk for osteonecrosis or loss of bone or part of the jaw due to non-living bone tissue. Treatment for osteoporosis can be very easy to manage or very difficult and painful. In very rare cases, it may be necessary to leave a small piece of tissue if the surgical procedure to retrieve it is too extensive. The exact duration of any complications cannot be determined and they may be irreversible. I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.
Alternatives to Suggested Treatment: Alternative treatments for missing teeth include 1) no treatment 2) new removable appliance or 3) other procedures – depending on the circumstances. However, continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissues of the mouth or remaining natural teeth.
Necessary Follow-up Care and Self Care: Implants and appliances must also be examined periodically and may need to be adjusted. I know that it is important for me to abide by the specific prescriptions and instructions given by my periodontist. I have received written pre-surgical and post-operative care instructions.
No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a periodontist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.
Publication of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public without my permission.

I HAVE BEEN FULLY INFORMED OF THE SURGICAL PROCEDURE, BENEFITS, RISKS AND ASSOCIATED PROCEDURES. I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND HAVE HAD ADEQUATE TIME TO REVIEW THIS DOCUMENT. I WILL COMPLY WITH THIS DOCUMENT AND MY PERIODONTIST/STAFF HAS ANSWERED ALL MY QUESTIONS TO MY SATISFACTION.

Patient's Printed Name	Signature	Date
Witness Printed Name	Signature	Date
Doctor's Printed Name	Signature	Date