

## **Implant patient information and consent form**

1. I fully understand the purpose and the nature of implant surgery and the treatment necessary to fit the implant under the gum or bone.
2. I have received a full oral examination by my dentist and alternatives this treatment has being explained to me. I have tried, or considered, the alternative methods and have decided upon an implant to secure a replacement tooth.
3. I understand that if I do not have the implant treatment any of the following could occur, bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. It is possible that temporomandibular joint (jaw) problems, headaches, pains to the back of the neck and facial muscles, and tired muscles when chewing may occur.
4. I have being informed of the possible risks and complications involved with surgery, drugs and anaesthesia. Such complications may include pain, swelling infection, and discoloration and numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration of these side effects is unpredictable, and may be irreversible. There may also be side effects such as inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used.
5. My dentist has explained that is not possible to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
6. It has being explained that in some instances implants fail and must be removed. I have being informed and understand that the practice of dentistry is not an exact science, no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

7. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my Dentists home care instructions. I agree to visit my dentist for regular check-ups as instructed.
8. I agree to the type of anaesthesia recommended by the dentist. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or until I am fully recovered from the effects of the anaesthesia or drugs prescribed 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, anaesthetics/pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry provided that my identity is not revealed (unless otherwise agreed).
11. I request and authorise medical/dental services for me, including implants and other necessary surgery. I also approve any modification in design, materials. Or care, if it is felt this is for my best interest.
12. I give my consent for contact with my GP with the charges for any reports to be passed on to me.

