MOORE FAMILY DENTAL CARE

900 E Shiloh Rd. • Corinth, MS 38834 • (662) 287-1171

IMPLANTS AND RELATED CONSENT

Patient Name: _____ Date: _____

1. The purpose and the nature of the implant surgery procedures have been explained to you, including what is necessary to place the implant under the gum into the bone.

2. A doctor has carefully examined your mouth. Alternatives to this treatment have been explained. You have tried or considered these methods but desire an implant to help secure the replaced missing teeth. Your questions have been answered.

3. You have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection 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 thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, and allergic reactions to drugs or medications used. In rare cases, such complications may be life-threatening.

4. You have been informed that if nothing is done any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, and/or looseness of teeth followed by need of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. In addition, you have been informed that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.

5. Your doctor has explained to you that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of an implant.

6. It has been explained to you that in some instances implants fail and must be removed, and also that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of the results of treatment or surgery can be made. You have been informed that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with removal.

7. You have been informed that excessive smoking, alcohol, or blood sugar may affect gum healing and may limit the success of the implant. You agree to follow your doctor's home care instructions. You agree to report to your doctor for regular examinations as instructed.

8. To the best of your knowledge, you have provided an accurate report of your physical and mental health history. You have also reported any allergic or unusual reactions to drugs, food, or anesthetics.

Implant Tooth Number(s): _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____