Consent Form: Surgical Insertion of Dental Implants

Dental implants are used as a basis for oral rehabilitation in patients who are missing one tooth or more. The insertion of a dental implant is a surgical procedure performed under local anesthesia.

Name of patient: _____
Last Name First Name Father's Name I.D.

I hereby declare and confirm that I received detailed verbal explanation from Dr. _____
Last name First Name

about the treatment which will be provided to me using dental implants in the upper and/or lower jaw. Details of treatment (type, location and quantity): _____
_____ (Hereinafter: the "Principal Treatment").

I have been informed of the treatment necessary for the insertion of the dental implants, including the expected results and possible alternative treatments under the circumstances of the case. I considered the alternative treatments before choosing the dental implants insertion treatment.

It was explained to me that smoking, untreated gum disease and diabetes significantly heighten the risk of failed implantation.
I was also informed of the importance of quitting smoking before and after the treatment, treating gum disease and keeping diabetes under control.
I was also explained that undergoing surgical treatment while taking medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma, especially steroids, smoking and diabetes enhances the risk of chronic inflammation and even necrosis of the jaw bone.

I have also been informed of the side effects of the Principal Treatment, including: Significant swelling, pain, subcutaneous hematomas and temporary mouth opening limitation.
Furthermore, I have been informed of the risks and complications related to the Principal Treatment, including: Infection, injury to facial nerves during implantation, i.e. temporary or permanent loss of sensation in the affected site and possible injury to the upper jaw (Maxillary) sinus during treatment of the upper jaw that will require further treatment.

It has been further explained to me that the manner and duration of recovery of the bone and gums following insertion of dental implants are individual and unpredictable and may take about 2 weeks. I was informed of the possibility of dental implant failure and I understand that in such case, it will become necessary to remove the implant and/or to perform corrective treatment.
It has also been explained me, and I understand the importance of continuity of the treatment at the same place and of cooperation between the doctor performing the dental implant insertion and the doctor performing the rehabilitative treatment.
I understand the importance of providing accurate information regarding my health condition and of complying with all the instructions given to me by the treating staff/doctor, including maintaining oral hygiene, and receiving all necessary operative and prosthetic treatments and attending follow-up checkups on schedule as may be required.

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after I received an explanation of the risks and complications of anesthesia including impaired sensation in the lip or in the tongue, hematoma, swelling and temporary mouth opening limitation.
Should the Principal Treatment be performed under general anesthesia, the information about the anesthesia will be provided to me by an anesthetist.

_____
Date Patient's Signature

_____
Name of Guardian (Relationship) Guardian's Signature
(When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____
Name of Physician Signature License No.