Consent Form: Placement of Zygomatic and Tubero-Pterygoid Dental Implants

Dental implants are performed as a basis for oral rehabilitation in cases one tooth or more are missing.
The placement of a dental implant is a surgical procedure. Zygomatic and Tubero-Pteryoid implants were developed as rehabilitative solution for patients suffering from severe bone loss in the upper jaw that does not enable placement of conventional dental implants. The implants designated for placement in the zygomatic bone, in the tuberosity or in the pterygoid region for the purpose of dental rehabilitation.

Name of patient: _____

Last Name First Name Father's Name ID. No.

I declare and confirm that I received a detailed verbal information from:

Dr. _____

Last name First Name

on treating me using zygomatic and/or Tubero-Pterygoid implants in the upper jaw. Details (type, location and quantity): _____ **(Hereinafter: The Principal Treatment").**

I was informed of the treatment necessary for the placement of a dental implant, including the expected results and possible alternative treatments under the circumstances of my condition. I have considered the alternative treatments before choosing this treatment.

It was explained to me that smoking, untreated gum disease and diabetes significantly enhance the risk of dental implantation failure. I was also informed of the importance of quitting smoking before and after the treatment, of treating gum disease and of controlling diabetes. It was further explained to me that undergoing surgical treatment while taking medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma, especially combined with steroid therapy, smoking and diabetes enhances the risk of chronic inflammation and even necrosis of the jaw bones.

I was informed of the side effects of the Principal Treatment, including: considerable swelling, pain, subcutaneous hematoma and temporary limitation in mouth opening.

I was also informed of the risks and complications related to the Principal Treatment, including: infection, injury to facial nerves during implantation, which means temporary or permanent impairment of sensation, possible injury to the maxillary sinus during treatment of the upper jaw, which may require further treatment and the development of sinusitis shortly after the treatment and/or at a later date. There is also a risk of injury to major anatomical structures such as the eye orbit, the eye ball and brain, fractures of the zygomatic bone and injury to central blood vessels.

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. 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 to local anesthesia, after being informed of the risks and complications of anesthesia including loss of sensation in the lip and/or tongue and/or chin and/or face, hematoma, swelling and temporary limitation in mouth opening. Should the Principal Treatment be performed under general anesthesia or under intravenous sedation, the anesthetic technique would be explained to me by an anesthesiologist.

_____

Date Patient's Signature

_____

Name of Guardian (relationship) Guardian's Signature

(When patient is legally incompetent, a minor or mentally ill)

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

_____ _____ _____

Name of Physician Signature License No.