

DENTAL IMPLANT CONSENT

I am asking you to sign this consent form per California law to obtain your consent to undergo this treatment. Also, I need you to agree that you are satisfied with the discussions relating the benefits, alternatives and risks of this treatment. Any treatment I recommend is one that I would have done on myself under your health conditions and at any time you have questions I will be pleased to explain.

I understand the implant procedure designed for me will involve placing metal fixtures in my jaw to replace missing teeth or to hold a denture or bridge. Dr. Daffurn has explained the procedure as much as I care to know.

I understand the benefits to this method of dental treatment are – no need to treat or grind on the neighbor teeth and a more natural/comfortable dental condition without fixed or removable bridges.

I understand if nothing is done I may experience tooth movement related to missing tooth spaces. This may result in less convenient/comfortable chewing conditions, periodontal (gum) problems and unfavorable appearance.

I understand there are alternative treatments. Fixed bridge work involves grinding down neighboring teeth and some increased maintenance. Removable appliances are less convenient because they are bulky and can feel troublesome to control and clean. In the case of full lower dentures, they are very loose.

I understand that during this implant procedure conditions may appear different than expected warranting a change in treatment or outcome. Dr. Daffurn will review this new information with me and I can decide the most successful alternative. Dr. Daffurn may request I see another doctor for a consult.

I understand that a great deal of healing success depends upon my treating the surgical site by gently brushing and avoiding any pressure in that area. Long term success depends on good oral hygiene throughout my mouth and regular visits to have my teeth cleaned. I understand that smoking, alcohol and improper dietary practices may affect bone and gum healing and limit the longevity of the implant.

I have given an accurate report of my physical and mental health history.

Allergies _____ Bleeding problems _____
Drug reactions _____

I have been advised of the possible risks and complications with implant procedures and drugs used. These include post-operative soreness, swelling and discoloration of the skin. There may be damage to adjacent teeth or to the nerves of the lower jaw resulting in numbness, temporary or permanent to the gums, tongue, lip or chin. These events are very rare and unlikely, but are known to have occurred in other offices.

I understand there is a possibility that the implant will not integrate (heal) and have to be removed. There is no way to estimate the longevity of a dental implant. I agree to report immediately any pain or swelling around an implant.

I agree to allow Dr. Daffurn to show x-rays, photography and filming, without my identity if requested, for the advancement of implant dentistry.

___It is recommended that I have a bone grafting procedure. The materials used may include processed human bone. There has never been a complication from this material even though it is being used hundreds of times every day. Dr Daffurn prefers this material because of all grafting materials, it has the highest success rate of regenerating natural bone.

If the implant does not perform properly within three years of placement it will be removed by Dr. Daffurn at no charge. Whatever your costs may be, you will get a credit towards an alternative treatment.

Date: _____

Name: _____

Signature: _____