

PATIENT: _____
DATE: _____

IMPLANT SURGERY INFORMED CONSENT

I have chosen to undergo implant surgery in order to replace the following teeth :

UPPER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	LOWER LEFT

PURPOSE OF THE TREATMENT:

Implants are utilized to replace one or more missing teeth and to improve function and appearance. The surgical procedure may last from thirty to ninety (30-90) minutes. The wound will be closed with dissolving stitches. Home care instructions and required prescriptions will be provided after the surgery. I will be seen in the office in one week to check the surgical site, and to be shown how to care for the site. It may take five to seven (5-7) days for my mouth to feel comfortable, and another two to four (2-4) weeks for the tissue around the site to heal completely. I have been asked to refrain from usual activity for a period of one (1) week. If I have been prescribed a sedative, I will be drowsy following surgery and have arranged to have a responsible adult available to take me home.

I understand that the complete implant procedure will span over the course of approximately 36 weeks. I will comply with all necessary appointments and instructions and understand that this is a commitment to treatment.

BENEFITS OF THE TREATMENT:

Implants replace teeth without the restraints that conventional dentures entail. Function and appearance are restored.

RISKS OF THE TREATMENT:

Despite excellent skill and care, it is possible for complications to arise. Healing may be delayed without proper oral hygiene. Infection may also result. All patients with teeth in close proximity to the implant site must be monitored for three to six (3-6) weeks after removal.

Gums or tissues involved in the anaesthetic injection may be sore for several days following treatment. Swelling of the tissues around the injection site is possible and can be treated by applying pressure and cold (ie. ice packs) the day of treatment to the area of swelling for a minimum of 1-2 minutes. In addition, if freezing involves the lower jaws, there may be difficulty opening the jaw for the first few days. The soreness and stiffness will dissipate with time but warm salt water rinses or moist heat on the side of treatment will facilitate healing. Transient facial paralysis is a rare possibility upon anaesthetic injection, but it will almost always resolve itself without any future consequences.

Lower molar teeth often rest near the main nerve to the lower jaw and the nerve to the tongue. Sometimes, in spite of all precautions, nerves may be bruised upon placement of the implant. In this event, the result is altered sensation; usually partial or complete numbness of the lower lip, chin, and all the teeth on that side or the side or tip of the tongue. Although in most cases this is temporary, the sensation improving as

the nerve repairs and regenerates, it is possible for the numbness to last for months, years or permanently. The occurrence and duration of sensation loss is unpredictable. **Altered sensation does not affect one's appearance.**

In very rare cases, the density of bone is not strong enough and implant placement can result in a jaw fracture. In almost all cases, this can be predicted before surgery, and you will be informed of this possibility and treatment will not be pursued.

ALTERNATIVES TO THE TREATMENT:

Partial dentures, complete dentures and bridges are an alternative to implants that may be employed if the patient wants treatment completed in a shorter period of time or is not averse to the special care requirements of dentures.

I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material. I have been given the opportunity to ask questions.

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment.

I consent to the taking of photographs throughout the entire treatment procedure. Should these photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE	_____
LAB FEE (approx.)	_____
TOTAL FEE (approx.)	_____

Dated at London, Ontario, this _____ day of _____

SIGNED: _____
PATIENT

WITNESS: SIGNED: _____
Parent, Guardian or Nearest Kin if patient
is under the age of 18