

Ithaca Oral Surgery and Implant Center

Practice Limited to Oral
& Maxillofacial Surgery

Cayuga Professional Center
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Statement of Consent For Dental Implant Surgery

You have the right to be given information about your proposed implant placement so that you are able to make the decision whether or not to proceed with surgery. What you are being asked to sign is your acknowledgement that you understand the nature of the proposed treatment, the known risks associated with it, and the possible alternative treatments.

Patient: _____ **Date:** _____

Please initial by each hash on the left margin after reading that section. You may ask questions about these at any time.

____1. The implant procedures proposed have been explained to me in detail and I understand the basic procedure to surgically place a dental implant into my upper and/or lower jaws.

____2. I understand that incisions may be made in my mouth to expose the bone for implant surgery. These dental implants may support a crown/cap, a bridge, or a denture. The crown/cap, bridge or denture that will later be attached to the implant(s) will be made and attached by Dr. _____ with separate charges/costs by that office.

____3. I understand that some implants may need an additional surgery to uncover them at 3-4 months. In some cases, there is no second surgery required. No guarantee can be or has been given that the implant(s) will be successful for a specific time period. Once the implant has been inserted, the entire treatment plan must be followed and completed on schedule; otherwise, it may not be successful. I understand that there will be no refund of the fees in the event of failure after one year, but there are circumstances that replacement will be at cost if likely due to unforeseen surgical or biological issues.

____4. I have been informed of possible alternative methods of treatment (if any) including: no treatment, making the jaws better for dentures by gum or bone surgery or other methods of replacing missing teeth. The advantages and disadvantages of these methods have been explained and I choose implant dentistry.

____5. Dr. Noren has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure, and in this instance, such risks include but are not limited to:

____A. Post-operative discomfort and swelling that may require several days of at-home rest/recuperation.

- B. Prolonged of heavy bleeding that may require additional treatment.
 - C. Injury or damage to adjacent teeth or roots of adjacent teeth.
 - D. Post-op infection that may require antibiotics or additional treatment.
 - E. Stretching of the corners of the mouth that may cause cracking and/or bruising.
 - F. Restricted mouth opening for several days; this can be related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ).
 - G. Injury to nerve branches in the lower jaw resulting in numbness, pain or tingling of the chin, lips, cheek, gums or tongue on the operated sides. These symptoms may persist for days, weeks or even rarely, permanently.
 - H. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment and/or surgery. There may be persistent sinus symptoms requiring certain medications, treatments and recovery time.
 - I. Fracture of a section of jaw or perforation of the bony plates.
 - J. Use of other materials, which may have to be removed at a later date.
 - K. Bone loss around implants.
 - L. Implant or prosthesis failure, or loss of the implant due to rejection by the body.
6. It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitate delay of the intended procedure at a later date, or an additional procedure from that planned. I authorize Dr. Noren and his staff to perform such additional procedures as are necessary and desirable in his professional judgment. These additional procedures may include bone or soft tissue grafting, anesthesia medications, or removal of bone or soft tissue for biopsy.
7. I consent to the administration of anesthesia that I have chosen as:
- local only
 - local with nitrous/laughing gas and oxygen
 - local with oral premedication
 - local with IV sedation

___8. Anesthesia risks with IV sedation may include but are not limited to: discomfort, swelling, bruising, infection and allergic reactions. Inflammation of the vein at the intravenous injection site (phlebitis) may require additional treatment at times. Nausea and vomiting, although rare, may result. Although generally very safe, IV sedation is nevertheless a serious procedure and carries potentially life-threatening risks. Generally however, IV sedation planned for implant surgery is light to moderate and is generally low risk in relatively healthy individuals.

___9. YOUR OBLIGATIONS IF IV SEDATION IS CHOSEN

___a. Because anesthetic medications may cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours in rare cases.

___b. During recovery (24 hours) you legally should not drive, operate complicated machinery or devices, or make important legal decisions such as signing documents.

___c. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR IV SEDATION. TO DO OTHERWISE MAY BE LIFE-THREATENING. You may drink water up to 3 hours prior but no other liquids or food.**

___d. It is important to take any regular medications (high blood pressure, antibiotics, etc) unless told otherwise by Dr. Noren or your physician, using a small sip of water.

___e. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment(s).

Signatures of Consent

My signature below signifies that all practical questions have been answered to my satisfaction regarding this consent and I fully understand the risks and benefits of the proposed surgery and anesthesia. I certify that I speak, read and write in English or that it has been adequately translated.

BEFORE SIGNING, PLEASE ASK THE DOCTOR OR STAFF ANY REMAINING QUESTIONS YOU MAY HAVE CONCERNING THIS CONSENT FORM.

I understand the surgical and anesthesia procedures to be performed after consent to be:

Placement of () dental implant(s) at: _____

_____ utilizing _____ anesthesia.

Patient

Date

Doctor

Date

Witness

Date

I additionally agree that I will follow up as deemed necessary with Dr. Noren and the restoring dentist_____, which may be over a period of years. Failure to follow up with either above Dr. can result in missed conditions that can lead to implant failure in some cases. If I move, I may allow either Dr. to help me establish a new dental clinic relationship with a well-trained dentist experienced in implant dentistry, if I so agree. In particular, cleaning around dental implants requires either plastic or titanium instruments by a dental hygienist. If not used, the implant surface may be damaged resulting in implant loss in severe cases.

Patient

Date