DR.KATBAB DENTISTRY

BLOOD BRESSURE: _____

# CONSENT TO IMPLANT PLACEMENT AND ANESTHESIA

**Instructions To Patient:**
Please take this document home and read it carefully. Note any questions you might have in the area provided in Paragraph 15. Bring this back to our office at your next appointment and the doctor will review it with you before signing on page 4.

**1.** My doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant (s) either on, in, or through the bone, and I understand that the most common types of implants available are subperiosteal (on the bone), endosteal (in the bone), and transosteal (through the bone). The implant type recommended for my specific condition is circled above. I also understand that endosteal implants (more commonly known as root form) generally have the most predictable results. I further understand that subperiosteal implants, if an option for me, are not widely used but will negate the necessity of my having the bone grafting and other surgical procedures which would be necessary for the placement of root form implants. I understand that the risk associated with the use of a subperiosteal implant is the failure and loss of the implant that could further reduce the minimal amount of existing bone that I now have, requiring more extensive bone grafting and other surgical procedures at some future time. I promise to, and accept responsibility for failing to, return to this office for examinations and any recommended treatment, at least every 6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold my dentist harmless if my implant(s) fail as a result of not maintaining an ongoing examination and preventive maintenance routine as directed by my dentist.

**2.** I have further been informed that if no treatment is elected to replace the missing teeth or existing dentures, the non-treatment risks include, but are not limited to:

**(a)** Maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but progressive dissolution of the underlying denture-supporting jaw bone;

**(b)** Any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time;

**(c)** Drifting, tilting and/or extrusion of remaining teeth; (d) Looseness of teeth, periodontal disease (gum and bone), possibly followed by extraction (s); _____ Initial 2 (e) A potential jaw joint problem (TMJ/TMD) caused by a deficient, collapsed or otherwise improper bite.

**INITIAL_____**

**3.** I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post surgical dental procedures. I am further aware that there is a risk that the implant placement may fail, through no one's fault, which then might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.

**4.** I understand that implant success is dependent upon a number of variables including, but not limited to: individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.

**5.** I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia and related drugs including, but not limited to: failure of the implant (s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures. I understand that any of these complications could occur even when all dental procedures are properly performed.

**6.** I have been advised that smoking, alcohol or sugar consumption may effect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my dentist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will more than likely contribute to the failure of the implants.

**7.** I have also been advised that there is a minimal risk that the implant may break, which may require additional procedures to repair or replace the broken implant.

**8.** I authorize my dentist to perform dental services for me, including implants and other related surgery such as bone augmentation. I agree to the type of anesthesia (circled below) that has 3 been discussed with me and the potential side effects: local, IV sedation, or general anesthesia. I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or until fully recovered from the effects of the anesthesia or drugs given for my care. My dentist has also discussed the various kinds and types of bone augmentation material, and I have authorized him/her to select the material that he/she believes to be the best choice for my implant treatment.

**INITIAL_____**

**9.** If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from those now contemplated, and I am under general anesthesia or I.V. sedation, I further authorize my dentist to do whatever he/she deems reasonably necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure(s).

**10.** I approve any reasonable modifications in design, materials, or surgical procedures, if my dentist, in his/her professional judgment, decides it is in my best interest to do so.

**11**. To my knowledge, I have given an accurate report of my health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, dust; blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I understand that certain mental and/or emotional disorders may increase the risk of failure or contraindicate implant therapy and have therefore expressly circled either YES or NO to indicate whether or not I have had any past treatment or therapy of any kind or type for any mental or emotional condition.

**12.** I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records that identify me will be used without my express written consent.

**13.** I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.

**14**. I agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences, which result from not following my dentist's advice.

**15.** Questions I have to ask my dentist: _____

_____

_____

_____

_____

_____

**INITIAL_____**

**16.** I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION AND CONSENT TO IMPLANT PLACEMENT AND ANESTHESIA, AND ALL MY QUESTIONS, IF ANY, HAVE BEEN FULLY ANSWERED. I HAVE HAD THE OPPORTUNITY TO TAKE THIS DOCUMENT HOME AND REVIEW IT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY INITIAL ON EACH PAGE, ALONG WITH MY SIGNATURE BELOW, ESTABLISHES THAT I HAVE GIVEN MY INFORMED CONSENT TO PROCEED WITH TREATMENT.

I understand that this Consent to Treatment form and the treatment provided as described above be governed by the laws of the Province of and I consent to the Courts of the Province of having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment, whether based on alleged breach of contract or alleged.

Negligence in providing such treatment or on any other grounds whatsoever, and whether against the dentist(s) named in above or against any of his/her partners, associates, employees or staff.

I undertake and agree to not commence any action relating to such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment, or on any other grounds whatsoever, in any other legal jurisdiction outside of the Province of whether or not I may have a right to do so.

I acknowledge and understand that Dr. _____ has agreed to provide professional services for me conditional on this undertaking being given and honoured by me with regard to my declaring that the Province of has exclusive jurisdiction over any action, suit or proceeding and Dr. has made it clear that without my making this undertaking, he would not have agreed to provide treatment for me.

I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment described in above with Dr._____ and that I have agreed to make such, payment on the terms we discussed.

BY INITIALING HERE "_____", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAS BEEN SATISFACTORILY ANSWERED. BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

**INITIAL_____**

Print Name:_____

Signature of Patient: _____
Or Signature of Parent of Guardian (or other person authorized to consent for patient)

Relationship of Person Signing to Patient: _____
Note: When a patient is a minor and/or is otherwise incapable of consenting to the treatment, the consent of a parent, guardian or substitute decision maker must be obtained.

Date: _____

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness_____

Doctors Name: _____ Doctors Signature: _____