WILLIAM E. MASON, D.D.S., M.S.
MONICA A. LAMBLE, D.D.S., M.S.
PERIODONTICS & DENTAL IMPLANTS

205 Colony Drive North
Saginaw, Michigan 48638

WEB www.doctormasononline.com **TELEPHONE** (989) 792-4431 **FAX** (989) 792-4387

CONSENT FOR DENTAL IMPLANTS

Diagnosis: After careful oral examination and study of my dental condition, my doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

Recommended Treatment: In order to treat my condition, my doctor has recommended the use of root form dental implants. I understand that the procedure for dental implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.

___Recommended Extractions:

In order to treat this condition, Dr. Mason/Dr. Lamble has recommended that my treatment include extraction(s) of my tooth (teeth). I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment.

Surgical Phase of Procedure: I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Holes to receive the implants will be drilled in the jawbone, and the implants will be tapped or threaded into place. The implants will have to be fitted and held tightly in place during the healing phase.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my periodontist will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the bone of my jaw and thereby to assist in placement, closure, and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance can then begin.

Expected Benefits: The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage and retention for these teeth.

Risks and Complications: I understand that some patients do not respond successfully to dental implants and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to: post-surgical infection, bleeding, swelling, facial discoloration and transient pain. Occasionally, permanent numbness of the lip, tongue, teeth, chin, gum, jaw joint injuries or associated transient muscle spasm. On occasion, permanently increased tooth looseness, tooth sensitivity to hot or cold and sweet or acidic foods, shrinkage of the gum upon healing. Resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign objects may occur. Although relatively uncommon, the exact duration of any complications cannot be determined, and they may be irreversible.

I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to be done, or at any time thereafter.

Alternatives to Suggested Treatment: Alternative treatments for missing teeth include no treatment, new removable appliances, and other procedures- - depending on the circumstances. However, continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissue of my mouth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my dentist or prosthodontist. Implants, natural teeth and appliances have to be maintained daily in a clean, hygienic manner.

Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my doctor.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a doctor cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of present condition, including the possible loss of the implant or other teeth, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays, or any other viewings of my care and treatment during or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Patient Consent: I have been fully informed of the nature of dental implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during consultation and in the treatment plan presentation as described in this document.

I also consent to the use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my dentist's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the bone of my jaw and thereby to assist in placement, closure, and security of my implants.

Date__/_/__
*PLEASE LIST ALL MEDICATIONS/DRUGS
TAKEN IN THE LAST 24 HOURS.

_____
_____
_____

Date __/_/_
*PLEASE LIST ALL MEDICATIONS/DRUGS
TAKEN IN THE LAST 24 HOURS.

_____
_____
_____

Yes☐ No☐ If you are a female and taking birth control pills: By signing below I certify that when taking an antibiotic, I must use other forms of birth control for up to one month after finishing the antibiotic.

Yes ☐ No☐ If you have taken or are taking bisphosphonate medications: By signing below I certify that I have been informed of and accept any risks I may have due to the use of these drugs.

Yes☐ No☐ If you are a regular blood donor or plan to donate in the future please be aware that donor agencies may not accept your blood if you have bone grafting material placed during this procedure. (Please inform us of your future plans)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____
(Printed Name of Patient, Parent, or Guardian)

_____
(Signature of Patient, Parent, or Guardian)

_____
(Printed Name of Witness)

_____
(Signature of Witness)

_____
William E. Mason, D.D.S., M.S.
Monica A. Lamble, D.D.S., M.S.

_____
(Printed Name of Patient, Parent or Guardian)

_____
(Signature of Patient, Parent, or Guardian)

_____
(Printed Name of Witness)

_____
(Signature of Witness)

_____
William E. Mason, D.D.S., M.S.
Monica A. Lamble, D.D.S., M.S.