



CONSENT FOR DENTAL IMPLANT

I hereby authorize Dr. Tuan Nhu to perform dental endosseous implant surgery on me, and I understand the general location in which dental implants will be placed. I also understand that Dr. Nhu is not an implant placement specialist, and I am declining immediate referral to a specialist at this time. I further understand that Dr. Nhu may cease treatment and make a referral to a specialist should any unanticipated difficulty or untoward event occur during or after treatment at my additional expense.

The details of the procedure have been explained to me, and I fully understand them. I understand that in order to perform dental implant placement surgery, my gum tissue will be cut, and bone will be removed. A full-thickness flap may or may not be made, and sutures may or may not be placed, depending on the situation.

I understand that the reasonable risks associated with implant placement surgery and subsequent restorations that would result in additional cost include, but are not limited to: nerve injury, excessive bleeding, swelling, bruising, numbness of the lip, sinus perforation, implant infection, rejection of the implant, fracture of the implant or components during or after placement of the implant or restoration, jaw bone fracture, allergic reaction, improper bite, failure of restorative and/or implant materials, muscle injury, TMJ injury, laceration of the tongue or cheek, loss of the prosthesis and/or the implant should disease develop for any reason around the implant, and wear and/or breakage of any part of the implant/restoration complex. Other complications may occur that cannot be anticipated at this time. Should any complication occur, I understand that there likely will be need for additional surgical procedures and/or to surgically remove the implant; alternative forms of treatment may then need to be used.

If I am taking any anticoagulant medication such as warfarin (Coumadin), aspirin, or any blood-thinning supplements, I have informed Dr. Nhu and acknowledge that we have discussed the risks of prolonged bleeding times. I understand that if bleeding does not stop in a reasonable time period that I will need to seek care at the nearest Emergency Room at my own expense.

I have been made aware that smoking will jeopardize the success of my implant therapy and the long term health of the entire implant/restoration complex. The excessive use of alcohol and sugar will likely have an adverse effect on my body's response to therapy and may, therefore, affect the success of my implant therapy.

I also understand that purified tissue regeneration materials from pig, cow, human cadaver, or of a synthetic nature may be used during the surgery to enhance the outcome of the procedure. These materials and their use as well as reasonable risks have been discussed with me. I further understand that I have the right to decline the use of these materials.

I understand that following the surgery, there may be a period of numbness of the jaw, some swelling, bleeding, discoloration and possible discomfort.

I understand that because the position of the nerves in the area of the dental implants cannot be clearly determined by x-rays (radiographs), injury to the nerves may be unavoidable and may result in loss of sensation to the chin, lips, and tongue for a period of time. I have been told that although it is usual for the numbness to be temporary it may, on rare occasions, be permanent.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the surgery or after the prosthesis is placed, I agree to report them to Dr. Nhu as soon as possible. I have been told that the success of the surgery depends upon my cooperation in keeping scheduled appointments, following home care instructions carefully, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I understand that the prognosis of my implant therapy will likely be optimized by receiving regular recare and maintenance procedures as recommended by my dentist and assume the responsibility of scheduling this important care at my own expense.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all my questions answered.

Patient Signature: _____

Date: _____

Dentist: _____

Date: _____

Witness: _____

Date: _____