

MIDWEST ORAL & MAXILLOFACIAL SURGERY, PA

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CONSENT FOR TWO-STAGE OSSEOUSINTEGRATED DENTAL IMPLANT PROCEDURE

Patient's Name _____

Date _____

If you have any questions, please ask your doctor **BEFORE** signing.

1. The surgical procedure proposed is: _____
2. I understand that incisions will be made in the upper and/or lower jaw for the purpose of placing one or more endosteal implants to serve as anchors for a missing tooth, tooth replacement, or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the type of implant to be used. I also understand that the crown, bridge or denture that will later be attached to this implant(s) will be made and attached by Dr. _____ and a separate charge will be made by that office.
3. I understand the implant(s) must remain covered by gum tissue for at least three months or longer, before it can be used, and that a second surgical procedure is required to uncover the top of the implant(s). No guarantee can be or has been given for the specific time period the implant(s) will last. It has been explained to me that once the implant(s) is/are inserted, **the entire treatment plan must be followed and completed on schedule.** If this is not done, the implant(s) may fail.
4. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure which include, but are not limited to:
 - A. Swelling and/or bruising and discomfort in the surgical area.
 - B. Stretching of the corners of the mouth resulting in cracking or bruising.
 - C. Injury or damage to adjacent teeth or roots of adjacent teeth.
 - D. Post-operative infection, including sinus infection (for upper implants), may require additional treatment. In rare instances an opening may develop between your mouth and sinus, requiring additional treatment.
 - E. Possible injury to nerve branches in the bone resulting in numbness, pain or tingling of the lips, cheek, gums or teeth. These symptoms may persist for several weeks, months or, in rare instances, may be permanent.
 - F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ).
 - G. Jaw fracture, while quite rare, is possible.
 - H. Bone loss around implants.
 - I. Implant or prosthesis fracture, or loss of the implant due to rejection by the body.
 - J. Prolonged heavy bleeding that may require additional treatment.

5. **Anesthetic risks include:**
- A. Nausea and vomiting.
 - B. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment.
 - C. Pain, swelling, inflammation, or infection of the area of the injection.
 - D. Injury to nerves or blood vessels in the area.
 - E. Disorientation, confusion, or prolonged drowsiness after surgery.
 - F. Cardiovascular or respiratory responses which may lead to heart attack, stroke, or death.
6. **Your obligations if IV anesthesia is used:**
- A. Because anesthetic medications 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.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a small sip of water.
7. I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in the procedure.
8. **The anesthesia I have chosen for my surgery is:**
- ☐ Local Anesthesia ("Novocaine")
 - ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia ("Laughing Gas")
 - ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia and Oral Sedation (Children)
 - ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia and IV Sedation/General Sedation

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, and that all my questions were answered to my satisfaction.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date