Family Smile Center, LLC
5950 Frederick Crossing Lane, Suite 201
Frederick, MD 21704
301-663-9484

Implant Patient Information and Consent Form

1. I have been informed and I understand the purpose and the nature of the dental implant surgery procedure. I understand what is necessary to accomplish the placement of implants into bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire dental implants.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, nitrous oxide, and local anesthesia. Such complications include pain, swelling, infection, and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reactions to drugs or medications used, etc.

4. I understand that if nothing is done, any of the following could occur; loss of bone, gum tissue inflammation, infection, nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of implants.

6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of treatment or surgery can be made.

7. I understand that smoking, alcohol, or sugar may affect gum healing and may limit the success of the implants. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree not to operate a motor vehicle or hazardous device while taking medications that may impair my judgment, such as narcotic analgesics or oral sedatives.

9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.

10. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

11. I request and authorize medical / dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

It is my decision to forgo alternative treatments and have dental implants placed. I understand the risks and consequences of this type of treatment. All of my questions have been answered.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____ _____

Signature of Doctor Witness