CONSENT FOR THE PLACEMENT OF DENTAL IMPLANTS

An explanation of your need for dental implants, their purpose and benefits, the surgeries related to their placement and exposure, and the possible complications as well as alternatives to their use were discussed with you at your consultation. We obtained your verbal consent to undergo the implant surgical treatment planned for you. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Purpose of Implants: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

Alternative Treatment: Reasonable alternatives to implants have been explained to me. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

Type of Implant: I am aware that the type of implant to be used on me is one which is placed into the jaw bone; that this is done by first reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone, and covering the bone and implant with the gum flap.

Surgical Procedures: I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge, or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed. I also understand that sometimes the implant(s) is covered with a bone graft material or a membrane to further enhance healing and that this may necessitate an additional procedure to remove the membrane.

Risks: Risks related to this surgery include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloring, perforation of the upper jaw sinus or nasal cavity during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth, or chin, jaw joint injuries or associated muscle spasms, bone fractures, and slow healing. Prosthetic risks include, but are not limited to, unsuccessful union of the implant(s) to the jaw bone, and/or stress metal fracture of the implant(s). Risks related to the anesthetics include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness and/or discoloration or blockage along a vein at the injection site.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant(s) will be permanently retained, but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long-term success cannot be promised.

Consent to Unforeseen Conditions: During treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating doctor.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

CONSENT FOR THE PLACEMENT OF DENTAL IMPLANTS

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to the placement of dental implant(s) as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of additional teeth or termination of the procedure prior to the completion of all of the extraction/surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	

CONSENT FOR TOOTH EXTRACTION AND THE SIMULTANEOUS USE OF BONE GRAFTING IN CONJUNCTION TO ATTEMPT RIDGE AUGMENTATION

An explanation of your need for extraction and ridge augmentation by the use of freeze-dried allograft bone and guided tissue regeneration, their purpose and benefits, the surgery related to this procedure, and the possible complications as well as alternatives to its use were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Suggested Treatment: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me. The tooth/teeth to be removed are checked below:

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

I have been informed that in areas of my jaw where I will be having teeth removed, there would be benefit to the support of conventional dental prosthetics for the anchorage of dental implants if simultaneous bone augmentation is performed.

Description of the Procedure: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw bone surface, teeth are removed, the extraction sites are cleansed of any infected tissue, the graft material placed into the extraction sockets and on the surface of the bone and then a Guided Tissue Barrier Membrane may be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration and to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth and/or together.

Description of the Graft Material: Bone Allograft - This is bone tissue of deceased persons donated by their next of kin. All donors are screened by physicians and other healthcare workers to prevent the transmission of disease to the person receiving the graft. They are tested for hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes the demineralization of the bone and its preservation by the process of freeze-drying. In addition, bone processed similar to the above descriptions after harvesting from bovine sources can be used as well as artificial bone-like substances.

Risks Related to the Procedure: Risks related to surgery with extraction and ridge bone regeneration by the use of bone grafts might include, but are not limited to: fracture of the tooth/teeth during extraction, retention of part of a root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

Alternatives to the Procedure: These may include: (1) No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth, a less than satisfactory dental prosthetic result. (2) Building up the ridge with soft tissue grafting which would not increase the possibility of using dental implants. (3) Extending the depth of the cheek pouch by surgery with or without the use of a soft tissue graft which would not increase the possibility of using dental implants or the esthetics or phonetics related to design of a fixed bridge.

CONSENT FOR TOOTH EXTRACTION AND THE SIMULTANEOUS USE OF BONE GRAFTING IN CONJUNCTION TO ATTEMPT RIDGE AUGMENTATION

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infection, or further bone loss or gum recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of the surgery.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	

CONSENT FOR THE USE OF BONE REGENERATIVE PROCEDURES

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroys some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard-to-clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health.

Recommended Treatment: In order to treat this condition, the periodontist has recommended that my treatment include bone regenerative surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, my gum will be opened to permit better access to the gum roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped.

Graft material will be placed in the areas of bone loss around the teeth. Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes may be used with or without graft material - depending on the type of bone defect present. My gum will be sutured back into position over the above materials, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of bone regenerative surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth. The use of bone, bone graft material, or the placement of a membrane is intended to enhance bone and gum healing.

Principal Risks and Complications: I understand that some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases the involved teeth may ultimately be lost. I understand that complications may result from the periodontal surgery involving bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to, post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanently increased tooth looseness, tooth sensitivity to hot, cold, 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, adverse impact on speech, allergic reactions, and accidental swallowing of foreign matter. In the event that donated tissue is used for the graft, the tissue should have been tested for hepatitis, syphilis, and other infectious disease. Nevertheless, there is a remote possibility that tests will not determine the presence of diseases in a particular donor tissue. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not entirely successful. In addition, the success of bone regenerative procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of the teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge I have reported to my periodontist my prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: Alternatives to periodontal surgery with bone regenerative surgery include: (1) no treatment – with the expectation of possible advancement of my condition which may result in premature loss of teeth, (2) extraction of a tooth or teeth involved with periodontal disease, (3) non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medications, in an attempt further to reduce bacteria and tartar under the gum line – with the expectation that this may not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of teeth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my periodontist may make recommendations for the replacement of restorations, the replacement of existing restorations or their modification, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that the periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by my periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

No Warranty of Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict the absolute certainty of success. There exists the risk of failure, relapse, and additional treatment or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Use of Records for Reimbursement Purposes: I authorize photos, slides, x-rays, or other viewings of my care and treatment during or after its completion to be used for reimbursement purposes.

PATIENT CONSENT

I have been fully informed of the nature of bone regenerative surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up 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 periodontist. After thorough deliberation, I hereby consent to the performance of bone regenerative surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ _____

[Date] [Printed Name of Patient, Parent or Guardian]

_____

[Signature of Patient, Parent or Guardian]

_____ _____

[Date] [Printed Name of Witness]

_____

[Signature of Witness]

CONSENT FOR TOOTH REMOVAL

An explanation of your need for tooth removal was discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Diagnosis: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.

Suggested Treatment: It has been suggested that the tooth/teeth checked below be removed:

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

Description of the Procedure: After anesthetics have numbed the area to be operated, extraction will be accomplished by either the removal of the tooth/teeth or by surgical reflection of gum, possible removal of some bone around the tooth/teeth, and possible sectioning of tooth roots to facilitate removal of the tooth/teeth. After the extraction, tooth socket(s) (hole in jawbone left by tooth removal) will be inspected, possibly cleansed of debris or infected soft tissue, and when indicated, this soft tissue may be submitted for histological examination to determine if pathology was present. Finally, the gum and socket or gum tissue may be sutured and measures will be taken to reduce bleeding from the extracted area(s) after this procedure.

Risks Related to the Suggested Treatment: Risks related to tooth removal surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, fracture of the tooth/teeth during surgery, retention of part of a root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, swallowing of a tooth or fragments of a tooth, sensitivity to hot or cold or sweets or acidic foods, or shrinkage of the gum upon healing. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing/aspiration of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

Alternatives to the Suggested Treatment May Include:

1. No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth.
2. Root canal treatment, with the expectation that this may not eliminate infection in the area, or that I may still lose the tooth in the near future.
3. Restoration (filling or cap) of this tooth/these teeth with the expectation that it/they may be lost in the near future.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in eradicating all pre-existing symptoms or complaints. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the problems associated with this tooth/these teeth. However, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of

failure, relapse, selective retreatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement, despite the best of care.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

CONSENT FOR TOOTH REMOVAL

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and after thorough deliberation, I give my consent for the performance of any and all procedures related to tooth extraction as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth. I agree to report for appointments as needed following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	

Bita farhoumand, DDS
Diplomate, the American Board of Periodontology

Consent for Implant Placement for Fixed Prosthesis

This informed consent is given to Dr. Bita Farhoumand, hereafter referred to as Doctor, after first having had an explanation of the nature of the proposed treatment, the alternatives, and risks.

Alternative treatments: Overdenture (implant-assisted denture) or Complete Denture

Treatment risks:

MINOR COMPLICATIONS (likely to occur post-operatively)

_____Tissue ischemia, bone exposure

_____Hematoma, prolonged bleeding

_____Swelling

_____Temporary numbness or paresthesia of the chin, cheek, jaw, teeth, palate and face

_____Stiff and sore jaw that may make it difficult to open wide, talk, or chew for several days

MAJOR COMPLICATIONS

_____Acute and/or chronic sinus infection associated with sinus perforation during surgery. Most perforations will repair on their own, but in case of non-resolution, you may need to seek further treatment by an ENT specialist

_____Permanent numbness or paresthesia of the chi, cheek, jaw, teeth, palate, and face.

_____Graft/implant exposure

_____Graft/implant mobility

_____Bone loss around implants

_____Implant failure

Treatment expectations:

_____I expect to follow the food and oral hygiene protocol given to me by Doctor, consisting of soft food diet for approximately 4 months, unless otherwise advised by Doctor.

_____I will not smoke. If I choose to smoke, I understand both the increased short-term risks and long- term risks of implant failure that can lead to complications with and/or complete loss of the fixed-prosthesis. For example, the implants may fail to integrate to my bone, or they may present with bone loss that may compromise the implants and lead to future implant failure. There will be a charge for any additional work that may need to be performed by Doctor to replace and/or repair any failed and/or failing implants.

_____In the event that enough of my implants fail during the healing phase, or after the healing phase once treatment is complete, and a fixed prosthesis cannot be fabricated or replaced on the remaining implants, I understand that I may no longer be a candidate for fixed-hybrid prosthesis and I may only be eligible for an overdenture or a regular denture based on the availability of bone and other prognostic factors.

_____I understand there is an additional cost for removing any failed implants, regrafting, and/or replacing the failed implants that is not included in the original fee I have paid to Doctor.

_____I understand that it is at Doctor's discretion whether to replace any implants that fail during the healing phase.

_____I will allow Doctor to fabricate a bite appliance for me at the end of my treatment if it is determined that I "clench" or "grind" my teeth, and I will wear the necessary bite appliance as prescribed.

_____In addition to the bite appliance, Doctor may recommend masseter muscle botox injections every 3-4 months in order to prevent the harmful effects of grinding on my final prosthesis and implants as much as possible, such as fracture of the prostheses and implant failure due to overload.

_____I understand the warranty on the fixed prosthesis is seven (7) years from the date of delivery, and only applies if there are no implant failures and if all measures have been followed to protect the prosthesis such as wearing bite appliance as prescribed, in addition to botox treatment.

_____I understand that I may not receive a fixed provisional prosthesis the day of the surgery. Doctor may decide it is in my best interest to wear a removal provisional denture during a healing period of 4-6 months, and then have me transition into a fixed prosthesis afterward.

_____My “bite” post-surgery may feel different compared to that of my original dentures or teeth.

_____My provisional and final prosthesis (removal or fixed) may need to be adjusted in multiple visits.

_____I understand the new restorations may feel awkward until I become accustomed to them and I understand that pronouncing certain words may take practice.

_____I understand the Doctor will make every attempt to create a natural appearance, however, it may not be possible for proper support of the lip and facial contours.

_____I understand that it is up to the discretion of the Doctor to decide what material the final prosthesis will be made of (zirconia, acrylic, PMMA, etc.)

_____I understand that I must keep my implants and prosthesis clean by twice daily maintenance home cleanings, as well as regular check-ups and cleanings at my dentist’s office at least 3-4 times/year.

_____I understand that at least once a year the prosthesis will need to be removed to clean and check the underlying implants, and new screws will have to be purchased to tighten the prosthesis back onto the implants.

_____I elect to treat my condition by the proposed treatment rather than any alternative therapy. I hereby authorize and consent to Doctor and whomever she may designate to perform implant-placement for a fixed-hybrid prosthesis.

_____I understand that the proposed treatment contains no guarantee or warranty of success. It is not possible to predict individual results. Therapeutic results are always dependent on individual compliance.

_____I have been given a signed copy of this consent form.

I certify that I have read and understand this authorization for proposed treatment described above. I accept the risks in hopes of obtaining the desired beneficial result.

Patient/Guardian_____Witness _____

Doctor _____ Date _____

CONSENT FOR THE PERFORMANCE OF SINUS AUGMENTATION SURGERY

An explanation of your need for sinus augmentation, its purpose and benefits, the surgery involved in this procedure, and the possible complications as well as alternatives were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Purpose of Sinus Augmentation Surgery: I am aware that I do not have enough bone to anchor dental implants in the rear areas of my upper jaw where there are teeth missing. I have been informed that the purpose of this procedure is to stimulate the growth of bone in the lower portion of the sinus space above the rear portion of my upper jaw. It has been explained that the purpose of this is to provide adequate bone for the anchorage of dental implants which in turn will provide a foundation for dental prosthetic tooth replacement of teeth missing in my upper jaw.

Description of the Procedure: After anesthetics have numbed the area to be operated, the gum is reflected from the jaw surface so as to gain access to the side of the jaw which forms the side wall of the sinus. Next, a hole in this sinus wall is formed, gaining access to the sinus. Next, the membrane lining the sinus is raised from the bone lining the base of the sinus. Next, a bone graft material is placed into the space between the bone and the elevated sinus membrane. Finally, the gum is repositioned to cover the jaw including the hole into the sinus and is sutured back into place to close this wound.

Description of the Graft Material:

(1) Processed Bone Allograft - This is bone tissue of deceased persons donated by their next of kin. All donors are screened by physicians and other healthcare workers to prevent the transmission of disease to the person receiving the graft. They are tested for hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes preservation of the bone by the process of freeze-drying.

(2) Bone processed similar to the above descriptions after harvesting from bovine sources;

Risks Related to the Procedure: Risks related to sinus augmentation surgery with bone regeneration by the use of demineralized bone allografts may include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, or gum, jaw joint injuries or associated muscle spasms. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

Alternatives to the Procedure: These may include no treatment, with the expectation of (1) no replacement of missing upper teeth; (2) a less-than-satisfactory outcome to any form of prosthetic replacement of missing upper teeth; (3) continued advancement of bone loss in the area of missing upper back teeth with possible future erosion into the sinus, i.e., the formation of a hole between the mouth and sinus which could lead to the development of chronic infection in the sinus.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will provide enough bone for dental implant anchorage. It is anticipated that the surgery will provide benefit in producing some bone, but it cannot be reasonably predicted so as to guarantee the nature of the eventual prosthetic solution, i.e., fixed versus removable tooth replacement. Due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, despite the best of care.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not

limited to, extraction of hopeless teeth to enhance the outcome of this procedure or termination of the procedure prior to completion of all surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth, to the use of prescribed medications, and to the limitations in use of current removable partial or full dentures. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of the surgery.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

CONSENT FOR THE PERFORMANCE OF SINUS AUGMENTATION SURGERY

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to maxillary sinus augmentation surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	

CONSENT FOR PERIODONTAL SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard-to-clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health.

Recommended Treatment: In order to treat this condition, my periodontist has recommended that my treatment includes periodontal surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for modification or change from the anticipated surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the fullest extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, 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 matter. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed is important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: I understand that alternatives to periodontal surgery include: no treatment – with the expectation of possible advancement of my condition which may result in premature tooth loss; extraction of teeth involved with periodontal disease; and non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in a further attempt to reduce bacteria and tartar, which may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of teeth.

Necessary Follow-Up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my periodontist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the extraction of one or more of my teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

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. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Use of Records: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for reimbursement purposes.

PATIENT CONSENT

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up 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 periodontist. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

[Date] [Printed Name of Patient, Parent or Guardian]

_____

[Signature of Patient, Parent or Guardian]

_____ _____

[Date] [Printed Name of Witness]

_____

[Signature of Witness]

CONSENT FOR RIDGE AUGMENTATION SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gumline or crowns with edges under the gumline, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

Recommended Treatment: In order to treat this condition, my periodontist has recommended that ridge augmentation (gum grafting) procedures be performed in areas of my mouth with significant gum recession. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from elsewhere in my mouth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

Expected Benefits: The purpose of ridge augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gumline, or to prevent or treat root sensitivity or root decay.

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to ridge augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during the healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession or in increased spacing between the teeth.

I understand that complications may result from ridge augmentation or from anesthetics. These complications include, but are not limited to (1) post-surgical infection, (2) bleeding, swelling, and pain, (3) facial discoloration, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, (5) allergic reactions, and (6) accidental swallowing of foreign matter. The exact duration of any complications cannot be determined and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of ridge augmentation can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching and grinding of teeth, (6) inadequate oral hygiene, and (7) medications that I may be taking. To my knowledge I have reported to the periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in adhering to the personal daily care recommended by my periodontist and taking all prescribed medications is important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: My periodontist has explained alternative treatments for my gum recession and modification of technique for brushing my teeth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of ridge augmentation.

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

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. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Use of Records for Reimbursement Purposes: I authorize photos, slides, x-rays, or any other viewings of my care and treatment during or after its completion to be used for reimbursement purposes.

PATIENT CONSENT

I have been fully informed of the nature of ridge augmentation surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up 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 periodontist. After thorough deliberation, I hereby consent to the performance of ridge augmentation surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

[Date] [Printed Name of Patient, Parent or Guardian]

_____

[Signature of Patient, Parent or Guardian]

_____ _____

[Date] [Printed Name of Witness]

_____

[Signature of Witness]

Patient Name: _____ Date: _____

INFORMED CONSENT
DENTAL TREATMENT & RISKS ASSOCIATED WITH ORAL BISPHOSPHONATE USE

Because you are taking a type of drug called an oral bisphosphonate, you may be at risk for developing osteonecrosis of the jaw, and certain dental treatments may increase that risk. The degree of risk for osteonecrosis in patients taking oral bisphosphonates for osteoporosis is uncertain and warrants careful monitoring, and dental treatment should be with close association and consultation with your treating medical physician.

What is osteonecrosis of the jaw?
Bone is a living tissue with living cells and a blood supply. Osteonecrosis means death of bone which can occur from the loss of the blood supply or by a problem with the bone's ability to regrow. Very rarely, osteonecrosis of the jawbone has occurred in individuals taking oral bisphosphonates for treatment of osteoporosis or Paget's disease of bone. Dental treatments that involve the bone can make the condition worse.

What is the risk for developing osteonecrosis of the jaw?
Your risk for developing osteonecrosis of the jaw from using oral bisphosphonates is very small (estimated at less than one person per 100,000 person-years of exposure to the drugs Fosamax, Actonel or Boniva); but, if it does occur, it may be a serious condition with no known treatment so you should be aware of this complication. At this time, there is no way to determine who will develop the disease. However, the condition is rare and has just recently been associated with the use of oral bisphosphonates. It is important for you to understand that other factors may play a role in the development of osteonecrosis, such as other medications you are taking and health problems that you may have.

What are the risks associated with dental procedures?
Although the risk is low with any procedure, it is higher with procedures involving the bone and associated tissues, such as tooth extractions. Bisphosphonates have been associated with osteonecrosis of the jaw; with the mandible twice as frequently affected as the maxilla and most cases occurring following high-dose intravenous administration used for some cancer patients. Some 60% of cases are preceded by a dental surgical procedure and it has been suggested that bisphosphonate treatment should be postponed until after any dental work to eliminate potential sites of infection

What are the signs and symptoms of osteonecrosis of the jaw?
You should tell your dentist immediately if you have any of the following symptoms, now or in the months following treatment:

- ***feeling of numbness, heaviness or other sensations in your jaw***
- ***pain in your jaw***
- ***swelling of your jaw***
- ***loose teeth***
- ***drainage***
- ***exposed bone***

ACKNOWLEDGMENT OF INFORMED CONSENT

Dr. _____ and/or his/her staff have presented information to aid in the decision-making process. I have been given the opportunity to ask the doctor and/or staff members all questions I have about the proposed dental treatment and the risks associated with oral bisphosphonate use. I hereby acknowledge that the major treatment consideration and potential risks of dental treatment have been explained and presented to me. I have read and understand this consent form. I also understand that problems listed may or may not occur during dental treatment. I give our consent for the doctor and his staff to perform the following proposed specific dental care: _____
_____

Patient: _____ Date: _____