Richmond Oral and Maxillofacial Surgery, LLC
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Consent for Placement of Dental Implants

Patient Name:_____**Date:**_____

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

1. I understand incisions will be made inside my mouth for the purpose of placing one or more root form structures (implant) in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown (cap), bridge, or denture. I acknowledge that Drs. Partridge, Hornaday, or Alderman has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge, or denture that will later be attached to this implant will be made and attached by a general dentist or prosthodontist and that a separate charge will be made for that work by him or her. I acknowledge that the fee paid to Drs. Partridge, Hornaday, or Alderman is for the placement of the implant only.

2. I understand that the implant must remain covered by gum tissue for a period of time before it can be used and that **a second minor surgery may be required to uncover the top of the implant**. I give my consent for the uncovering of the implant(s) at a specified future time and that all the items contained within this consent will apply.

3. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.

4. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. Drs. Partridge, Hornaday, or Alderman has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:
    A. Postoperative discomfort and swelling that may require several days of at-home recuperation.
    B. Prolonged or heavy bleeding that may require additional treatment.
    C. Injury or damage to adjacent teeth or roots of adjacent teeth requiring root canal therapy or extraction.
    D. Postoperative infection that may require additional treatment.
    E. Injury to nerves: In the lower jaw there is a nerve canal for a nerve (inferior alveolar nerve) that supplies feeling to the lower lip, chin, tongue, teeth, gingiva (gums), and cheek. There is also a nerve (lingual nerve) that lies outside the lower jaw that supplies feeling to the tongue. There is a possibility that these nerves could be bumped, bruised, cut, or damaged during the placement of implants in the lower jaw. If injury were to occur to any one of the previously mentioned nerves, numbness of the lower lip, chin, tongue, teeth, gingiva (gums), and/or cheek could occur. *Usually* this is temporary, but it **could be permanent**. Numbness of the tongue would also result in loss of taste. In some cases the implant may need to be removed.
    F. Opening into the maxillary sinus (a normal chamber above the upper back teeth) requiring additional treatment.
    G. If the sinus is intentionally entered (sinus lift procedure with grafting) there will usually be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.
    H. Fracture of the jaw. This would require additional surgery to correct such as wiring the jaws shut and/or application of plates and screws in the operating room under general anesthetic.

Initials_____Date_____

5. While performing the placement of my implant(s), I recognize that my doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may, in my doctor's judgment, require termination of my surgery. I authorize Drs. Partridge, Hornaday, or Alderman to perform such other procedure(s) as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

6. I also consent to the administration of local anesthetics and medications as may be deemed necessary or advisable for my comfort, health, and safety. If intravenous (IV) sedation is used, I understand that there may be soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Other rare complications of IV anesthesia may include allergic reaction to medications, respiratory problems that may require a breathing tube be placed, stroke, heart attack, heart failure, hospitalization, and/or death.

7. I have been made aware that certain medications, drugs, anesthetics and prescriptions that I may be given can cause drowsiness, and lack of awareness and coordination which also may be increased by the use of alcohol and other drugs. I understand that I should not use alcohol, operate a vehicle or other hazardous machinery, or make any legal decisions while under the influence of any medication, anesthesia, or prescription given by this office. I have been advised not to return to work while taking such medications, or until fully recovered from the effects of such medications, drugs, anesthetics and/or prescriptions. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.

8. I am also aware that intravenous (IV) sedation and many drugs are not recommended for use for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise my doctor if I am pregnant or possibly could be pregnant.

9. **I also have been informed by Drs. Partridge, Hornaday, or Alderman that antibiotics *can* and *may* interfere with the effectiveness of oral birth control pills and that I *can* and *may* become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.**

10. I understand and have been informed that it is extremely important that I maintain meticulous care of not only the implant but of my entire mouth. It has also been explained to me that smoking, alcohol, improper dietary practices, and oral habits such as grinding, clenching, and tongue thrusting may affect the success of the implant(s).

11. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to not have the proposed treatment performed or if I wish to try another method of treatment rather than undergo the surgical intervention proposed. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Drs. Partridge, Hornaday, or Alderman has proposed.

12. I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by Drs. Partridge, Hornaday, or Alderman and/or his assistants, and that I give my consent voluntarily.

13. I also certify that if I am not the patient that I am the *legal guardian and/or power of attorney* for the patient for whom I am completing this form.

Patient_____ Patient's Signature _____ Date _____

Parent/Legal Guardian/POA Signature _____ Date _____

Witnessed By _____ Date _____