Canandaigua Oral Surgery, PC
500 North Main Street
Canandaigua, NY 14424
585.394.3322
office@canandaiguaoralsurgery.com
www.canandaiguaoralsurgery.com

Consent for Dental Implant Surgery

I have been advised following careful study of my oral and dental condition that my missing tooth or teeth can be replaced with artificial tooth/teeth supported by one or more dental implants. I understand an implant is an artificial root in essence, and that following successful healing a second phase of treatment will be needed to make the implant into a functional tooth or teeth. This phase of treatment will be performed by another dentist (typically your dentist, but on occasion a prosthetic dental specialist), who is trained in the restoration of a root form implant. I understand that implant restoration can only be accomplished following a successful period of bone healing, usually a period of three to six months. Long term success is dependent on both a successful surgical insertion and prosthetic restoration, as well as careful and routinely scheduled maintenance both at home and with my dentist. Patient initials: _____

I have been advised that there will be a variable amount of postoperative discomfort and swelling following the surgical insertion of the implant(s), and that dentures usually cannot be worn during the first one to two weeks following surgery, and that alterations to my existing denture(s) may be needed during the healing phase. Patient initials: _____

I understand that not all patients respond successfully to dental implant placement. An implant may be unsuccessful due to infection or progressive bone loss over time. An implant may also be found to be unacceptable in position or angulation for prosthetic reasons, and may therefore not be usable. Secondary surgical procedures may be required for maintenance of the implant or the tissues supporting it over time. Patient initials: _____

Complications may result from the placement of dental implants. These complications are either temporary or may be permanent. These complications include, but are not strictly limited to: infection, bleeding, pain and swelling, bruising, transient or permanent loss of or change in feeling in the lip, chin, tongue, cheek, nose, gums and/or remaining teeth, damage to adjacent teeth, bone fracture, nasal or sinus perforation, jaw joint problems, restricted jaw movement, esthetic changes in the appearance of gum tissues, accidental swallowing of materials, and other less foreseeable complications. Patient Initials: _____

Dr Cary and/or my general dentist has discussed alternatives to treatment with implants with me. I understand them to be the construction of conventional new dentures, new bridges, other removable appliances, or to do nothing. Patient initials: _____

I understand that there will be benefits in using dental implants over more conventional appliances. These include the development of more stable and functional teeth. The implants provide support, anchorage, or retention for these new teeth. Patient initials: _____

I understand and acknowledge that no guarantee, or warranty or has been given to me that the proposed treatment will be successful. Due to individual patient considerations, Dr. Cary cannot guarantee a successful outcome. There exists the risk of failure at any time in the future, and additional treatment may be required. Patient initials: _____

I acknowledge that I have been fully informed of the nature of my condition and the indications for the use of root form implants in treating me. The procedure, its attendant risks and benefits, the anticipated healing period and the necessity for long term and careful follow-up has been explained. I understand my alternatives in treatment and the elective nature of using implants in general. I have read this document completely, have had my questions answered to my satisfaction, and do hereby give my consent for implant surgery as presented by Dr. Cary.

Number of Implants to be placed: _____

Implant position(s): _____

Patient Name: (printed) _____

Patient Signature: _____

Signature of legal guardian:_____
(patient is a minor or is unable to provide legal to give consent)

Date: _____

Doctor Signature: _____

Witness: _____