

PERIODONTAL & IMPLANT SURGEONS OF GREENVILLE

PATRICK L. JOHNSON, D.D.S.
PRESTON S. ALFRED, D.D.S., M.S.

IMPLANT PATIENT INFORMATION AND CONSENT

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the 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 an implant to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with my surgery, drugs, and 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 is inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible is 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 there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
6. It has been explained in some instances implants fail and must be removed. I have been informed and understand the practice of dentistry is not an exact science and no guarantees or assurance as to the outcome of the results of treatment or surgery can be made.
7. I understand excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. 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 to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
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, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography, film 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 (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 pertaining to the success of comprehensive treatment. I also approve any modification in design, materials, or care, as necessary for my treatment.

Printed Name of Patient or Parent/Guardian

Signature of Patient or Parent/Guardian

Date

Printed Name of Witness

Signature of Witness

Date