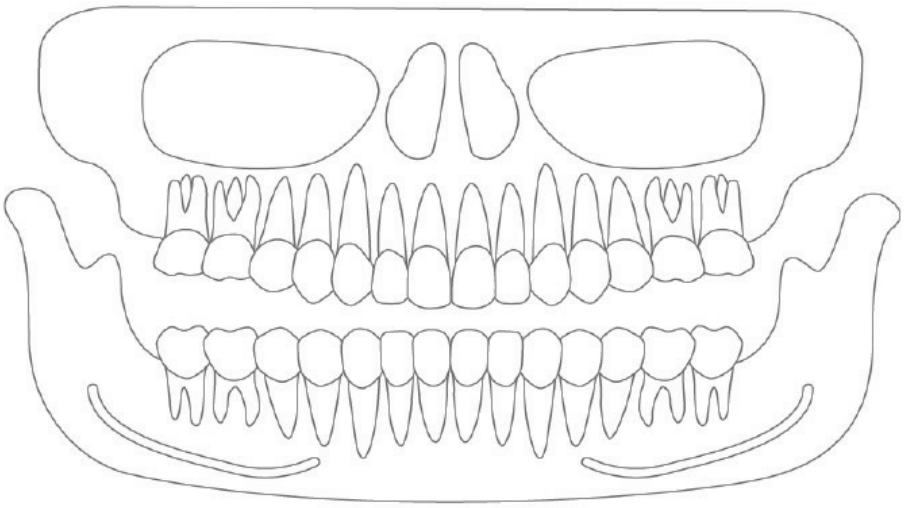
Surgery Consent Form

Dentist Name:

Patient Name:

1. SURGERY INFORMATION



Teeth Number	Name of product / Product Label	

2. TREATMENT PLAN

3. GENERAL HEALTH CHECK UP

Smoking and Alcohol

	YES	NO
Do you currently smoke?	○	○
Do you drink alcohol more than 3 times a week?	○	○

Physical condition

	YES	NO
Experienced any side effects from medication or injection?	○	○
Experienced any side effects from anaesthesia in the dental clinic?	○	○
Do you easily bruised or have trouble stop bleeding?	○	○
Do you grind your teeth while asleep?	○	○
Experienced pain or difficulty on breathing while walking?	○	○

Medical History

Are you diagnosed or on any medication with the following conditions? (Please check X)

☐ Cardiac disorder ☐ Hypertension ☐ Gastro enteric trouble ☐ Diabetes

☐ Liver disorder ☐ Thyroid disorder ☐ Otolaryngology disorder ☐ Osteoporosis

☐ Allergic diseases ☐ Mental disorder ☐ Mental disorder ☐ Other _____

If you are on any type of medication , please list them all below

	YES	NO
Have you recently hospitalised or had any surgery?	○	○
Have you recently got hurt or sick severely?	○	○

Female Only

	YES	NO
Pregnant or expecting a pregnancy?	○	○
Are you on breast feeding?	○	○

4. IMPLANT TREATMENT CONSENT FORM

- I have been informed and afforded the time to fully understand the purpose and the nature of the implant surgery procedure.

I understand what is necessary to accomplish the placement of the implant under gum on/or in the bone.

- My dentist 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.
- I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discolouration. 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 thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
- I understand that 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 a necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. Also, I am aware that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.
- My dentist has explained that there is no method to predict the gum and bone healing capabilities accurately in each patient following the placement of the implant.
- 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 the results of treatment or surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.
- I understand that excessive smoking, alcohol or blood sugar may affect gum healing and may limit the success of the implant. I agree to follow my dentist's home care instructions. I agree to report to my dentist for regular examinations as instructed.
- I agree to the type of anesthesia, depending on the choice of the dentist. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more o until fully recovered from the effects of the anesthesia or drugs given for my care.
- 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.
- I consent to photography, filming, recording, x-rays and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
- I request and authorize medical/dental services for myself, including bone grafts and other surgery. I fully understand the contemplated procedure, surgery or treatment conditions that mavvy become apparent which warrant, in the judgement of the dentist, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or case, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my dentist, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.

Initials: _____

Consent for the restoration of dental implants

- The purpose of dental implants is to provide stability, support and/or retention for a crown, fixed bridge, fixed denture or removable denture in the absence of natural teeth. Based upon thorough examination and discussion. I request the fabrication of an implant prosthesis. I approve any future modification in prosthetic design, materials or treatment if, in the dentist's professional judgement, it is in my best interest.
- I have been informed and afforded the time to fully understand the purpose and the nature of the implant restorative procedure. I understand what is necessary to accomplish the restoration of the implant previously inserted into or onto the bone and under the gum.
- Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant prosthesis to help secure the replacement of my missing teeth. The entire procedure has been fully explained, including the benefits and possible risks. I have been given the opportunity to ask questions regarding the procedure and they have been answered to my satisfaction. I have not asked for, nor have I received from anyone, a guarantee or the outcome of this procedure.
- The possible risks and complications for fixed prostheses include compromised appearance and/or lack of supporting the lips and cheeks as a result of inadequate bone; air escaping underneath the prosthesis while talking which may adversely affect speech and/or food entrapment underneath the prosthesis since space is necessary for home care the implants. The possible risks for removable prostheses include sore gums, food entrapment, the wearing of attachments, replacement of attachment components and initial problems with speech.
- Excessive forces, as grinding or clenching my teeth, on the implants may lead to loosening and/or fracture of the retaining screws or cement; fracture of the porcelain, metal or acrylic on the prosthesis; loosening and/or fracture of the implants; and/or loss of bone around the implants. Any of these may cause loss of the implants. Additional treatment and associated costs will be involved should this occur, including, but not limited to occlusal guard.
- I understand that if nothing is done any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, loosening of teeth followed by the necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and fatigued muscles when chewing. In addition, I am aware that if nothing is done at the present time, a future bone loss may cause the inability to place implants at a later date due to changes in oral or medical conditions.
- Follow-up care for the implants and prosthesis is critical to the success. It will be necessary to return to the office at regular intervals for examination and service. It has been made clear that failure on my part to keep my mouth, implant posts and prosthesis thoroughly clean my jeopardize the success of my implants. I realize that unforeseen long-term factors may necessitate additional surgery, modification or the implants or even surgical removal of the implants. I also understand that I will be financially responsible for long-term maintenance and/or any modifications required, including but not limited to cleanings, attachment replacements, x-rays and examinations.
- 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.
- I consent to photography, filming, recording, x-rays and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
- If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my dentist, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant restoration.

Initials: _____

Consent for bone graft surgery

- I have been informed and afforded the time to fully understand the purpose and the nature of the bone graft surgery procedure. I understand what is necessary to accomplish the placement of the bone graft under gum on/or in the bone.
- My dentist has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire a bone graft to help secure the replaced missing teeth.
- I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discolouration. 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 thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
- I understand that 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 a necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. Also, I am aware that if nothing is done an inability to place a bone graft or implants at a later date due to changes in oral or medical conditions could exist.
- My dentist has explained that there is no method to predict the gum and bone healing capabilities accurately in each patient following the placement of a bone graft. It has been explained that bone in its healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.
- It has been explained that in some instances bone grafts fail (mal-union, delayed union or non-union of the donor bone graft to the recipient bone site) and must be removed. It also has been explained to me lack of adequate bone growth into the bone graft replacement material could result in failure. 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 the results of treatment or surgery can be made. I am aware that there is a risk that the bone graft surgery may fail, which might require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. If the bone graft surgery fails I understand that alternative prosthetic measures may have to be considered.

I agree to the following procedure:

- Autogenous graft – which transplants bone from one region to another
- Donor site: Chin Edentulous area Maxillary tuberosity Ascending ramus Iliac crest Tibia
- Recipient site: Upper arch Lower arch Edentulous area Sinus
- Allograft – which transplants bone from one individual to a genetically non-identical individual of the same species. All allografts are processed from donors found to be negative by FDA approved tests for HBsAg, anti-HBc, anti-HCV, STS, antiHIV1/2 and anti-HTLV-I. Although efforts are made to ensure quality, most tissue banks make no claims concerning the biological or biomechanical properties of the provided allograft. All allografts have been collected, processed and distributed for use following the Standards of the American Association of Tissue Banks.
- Donor: Demineralized freeze-dried bone (DFDB) Freeze-dried bone
- Recipient site: Upper arch Lower arch Edentulous area Sinus
- Alloplast – implantation of synthetic/chemically derived bone substitutes or membranes
- Donor: Dense HA Resorbable HA Collagen membrane
- Recipient site: Upper arch Lower arch Edentulous area Sinus

Initials: _____

- I agree to the type of anesthesia, depending on the choice of the dentist. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more o until fully recovered from the effects of the anesthesia or drugs given for my care.
- 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.
- I consent to photography, filming, recording, x-rays and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
- I request and authorise medical/dental services for myself, including bone grafts and other surgery. I fully understand the contemplated procedure, surgery or treatment conditions that may become apparent which warrant, in the judgement of the dentist, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or case, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my dentist, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the bone graft procedure.

Initials: _____

5. PERSONAL INFORMATION- PATIENT

Patient Name:

Date of Birth:

Address:

Contacts:

☐ I have had the opportunity to discuss the surgery with the dentist and to ask questions. I have fully understood the purpose, consequence and procedure, possible complications and after-effects after surgery from the dentist in charge. I acknowledge that the treatment plan can change depending on my condition. I consent to the surgery as described.

DD/MM/YY SIGNATURE

6. PERSONAL INFORMATION- SURGEON

Dentist Name:

Clinic Name:

Contacts:

DD/MM/YY SIGNATURE