LUMA DENTAL

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DENTAL IMPLANT(S) CONSENT

Part 1 - Patient & Doctor Information

Patient Name: _____ Tooth/Teeth #: _____

Doctor Name: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

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Part 2 - Details of Consent

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Condition
My doctor has explained the nature of my condition to me: Missing tooth/teeth.

Procedure – Dental Implant
My physician has proposed the following procedure to treat or diagnose my condition: Dental implant. This means: Surgically place an implant into the supporting jawbone.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of surgery and anesthesia, many of which are **extremely unlikely** to occur, but can be alarming for the patient. Please take you time to read this document in full and discuss with your doctor in full, any questions or querie4s you may have.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct the doctor and his authorized associates and assistants to treat my condition.

2. The procedure I choose to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials of human, animal or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage and retention for these teeth.

3. I understand that this is nonetheless an **elective procedure**, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a bridge, a partial denture, full denture, or other options. I understand and choose to undergo the placement of root form implant(s).

4. I understand that my gum tissue will surgically be opened to expose the bone and that implants will be placed immediately by tapping or threading them into holes that have been drilled into my jaw bone. I understand that the gum tissue will then be stitched closed over or around the implant to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that the implants placed will be integrated in 3 to 9 months' time, depending on my personal healing ability.

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Part 3 - My Responsibility

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected. Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

Part 4 - Miscellaneous

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Photography
I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Miscellaneous
If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

Fees
I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

Part 5 - Signature

Understanding
I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I give my informed consent for surgery and anesthesia.

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Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. _____ to perform the procedure listed in the title above. I know that I am free to withdraw from treatment at any time.

_____ _____

Patient or Representative Signature: **Date:**

_____

If not the patient, what is your relationship to the patient?

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

_____ _____

Dentist Signature **Date:**