



**Braden C. Seamons, D.D.S.**

**Diplomate of the American Board of Periodontology**

REGENERATION   MICROSURGERY   ESTHETIC ENHANCEMENT   NONSURGICAL THERAPY   IMPLANTS

**INFORMED CONSENT  
FOR THE PLACEMENT AND RESTORATION  
OF OSSEOINTEGRATED DENTAL IMPLANTS**

- 1) This is my consent for the surgical placement, uncovering and restoration of dental implants(s) into my jaw. The implants must heal for 4 to 8 months before being surgically uncovered so the restoration can be made at a later date. The implants may then be used to support and retain partial dentures, complete dentures, or to replace single missing teeth. I have been informed of alternative methods of treatment along with their risks and benefits.
- 2) I understand that there is no way to predict the gum and bone healing response of each patient following implant placement. Factors such as general health, smoking, alcohol and poor diet may affect healing and the success of the implant.
- 3) It has been explained that there are risks associated with this treatment, including the possibility of pain, bleeding, swelling, and infection. Numbness and/or tingling of the lip, tongue, chin, gums, cheeks and any existing teeth can also occur, which may be temporary or permanent. Additionally, sinus complications, openings from the sinus to the mouth, bone fractures, injuries to adjacent tissues and apparent facial changes are possible. These problems may require later surgical correction including removal of the device. Furthermore, it has also been explained to me that the implant(s) may not work, or may later fail. I understand that failure of this implant method may result in failure of the bridge, partial or full denture but will usually not interfere with other types of future conventional denture treatment should that be necessary.

**NOTE: Please read and initial the following statements:**

\_\_\_\_ I agree to the use of a local anesthetic, and/or sedation depending upon the judgment of the dentist involved in my care.

\_\_\_\_ I understand that a bone graft material may need to be added to help support the implant. The graft material is usually a demineralized freeze-dried bone, which is obtained by certified tissue banks under strict conditions from human donors with no known diseases. The bone is then processed under strict conditions, which are known to kill bacteria and viruses. While transmission of infection by implanted biologic material can never be ruled out 100% of the time, this material is considered to be extremely safe with no instance of transmitted infection found in more than 10 years of use. Sometimes a synthetic membrane will be used to protect the bone graft. Some of these membranes need to be surgically removed at a later date.

\_\_\_\_ I have had an opportunity to discuss my past and current medical history including any serious problems and/or injuries with my doctors. I have disclosed any medications I am taking.

\_\_\_\_ I understand that I may be instructed not to wear my dentures for 2-3 weeks following implant placement. Compliance with this instruction is critical to successful implant treatment.

\_\_\_\_ Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol and other drugs. I understand not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs until fully recovered from the effects of the same. I will not be able to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

\_\_\_\_ I understand the need and importance completely with the recommendations of my doctors while I am under their care. Failure to do so could result in a less than optimum result.

\_\_\_\_ I understand the need and importance of maintaining proper oral hygiene. Like natural teeth, if dental implants are not properly cared for daily, they will lose supporting bone through disease and will need to be removed.

\_\_\_\_ I understand there is no warranty or guarantee as to the results or outcome of placement of implants and that my condition could actually become worse if the implant(s) fail.

I certify that I have read and fully understand the terms and words within this informed consent document and have had the opportunity to discuss the surgical operation and prosthetic restoration of my mouth to my satisfaction.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Patient's Signature.