21st Century Dental Care, P.C.

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Basking Ridge, NJ 07920

CONSENT FOR IMPLANT SURGERY

Patient's Name **Date**

Please initial each paragraph after reading. If you have any questions, please ask Dr. Friedman BEFORE initialing.

You have the right to be given information about your proposed implant placement so that you are able to make the decision as to weather to proceed with surgery. What you are being asked to sign is your acknowledgement that you understand the nature of the proposed treatment.

1. _____ I hereby authorize Dr. Friedman and assistant(s) to perform the procedure of surgical implant placement. The procedure has been explained to me and I understand the nature of the procedure.

2. _____ I understand that incision will be made inside my mouth for the purpose of placing one ore more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge or denture.

3. _____ I understand that sometimes (on occasion) the implant(s) must remain covered by gum tissue for at least three months before being used and that a second surgical procedure is required to uncover the top of the implant. It has been explained to me that once the implant is inserted, the entire treatment plan must be followed, and completed on schedule.

4. _____ I have been informed of possible alternative methods of treatment (if any).

5. _____ Dr. Friedman has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risk include, but are not limited to:

   A. Post-operating discomfort and swelling.
   B. Prolonged or heavy bleeding that may require additional treatment.
   C. Injury or damage to adjacent teeth or roots of adjacent teeth.
   D. Post-operative infection that may require additional treatment.
   E. Injury to nerve branches in the jaw or soft tissues resulting in numbness, pain or tingling of the chin, lips, cheek, gums, or tongue (including possible loss of taste sensation) on the operated side(s).

F. Opening into the sinus (a normal bony chamber above the upper back teeth) requires additional treatment.
G. Bone loss around implant(s).

6. _____ It has been explained to me that during the course of surgery unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from that set forth in the original course of treatment.

7. _____ The anesthesia I have chosen for my surgery is:

_____ Local Anesthesia

_____ Local Anesthesia with Nitrous Oxide/ Oxygen Analgesia

_____ Local Anesthesia with Oral Premedication

8. _____ I understand smoking is extremely detrimental to the success of my implant surgery. I agree to cease all use of tobacco for 2-3 weeks after surgery, including the later uncovering procedure (when necessary), and to make a strong efforts to give up smoking entirely.

9. _____ I understand that no guarantee of treatment results can be promised and I give my free and voluntary consent for treatment.

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved to the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian) Signature	**Date**
Doctor's Signature	**Date**
Witness's Signature	**Date**