**IMPLANT, GRAFTING, GUM SURGERY AND EXTRACTION**

**PATIENT**

**INFORMATION AND CONSENT FORM**

1. I have been informed and I understand the purpose and the nature of the surgery procedure. I understand what is necessary to accomplish the placement of the implant, bone grafting, gum grafting or tooth extraction.
2. My doctor has carefully examined my mouth. Alternatives to these treatments have been explained. I have considered these alternatives, but I desire to proceed with the implant \_\_\_\_\_, bone grafting \_\_\_\_\_, gum grafting \_\_\_\_\_, gum surgery \_\_\_\_\_, tooth extraction, other \_\_\_\_\_. **Check the applicable procedure.**
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, discoloration, graft or implant rejection. Prolonged or permanent numbness of the lip, tongue, chin, cheek, or teeth may occur. Also, possible are 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 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 extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the surgery.
6. 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 results of treatment or surgery can be made.
7. I understand that smoking, alcohol, and excessive sugar may affect gum healing and may limit the success of the surgery. 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 while taking the prescribed pain medication or the antianxiety medication. I agree to take antibiotic medication as prescribed.
9. To my knowledge I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs (including anesthetics), blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography and video recording of the procedure to be performed for the advancement dentistry, provided my identity is not revealed. Check if you do not give permission \_\_\_\_\_\_.
11. I request and authorize medical/dental services for myself, including implants, bone grafting, gum grafting, gum surgery, teeth extractions, including wisdom teeth. 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 pertinent to the success of comprehensive treatment. I approve any modifications in designs, materials, or care, if it is felt this is for my best interest.

Signature of Patient Date Signature of Witness Relationship to Patient

Signature of Doctor Date