SMILE DESIGN CENTER

Implant, Grafting, Gum Surgery and Extraction

Patient Information and Consent Form

Patient name: _____ Date: _____

1. I have been informed and I understand the purpose and the nature of the surgical procedure. I understand what is necessary to accomplish the treatment checked below.
2. **Procedures.** I wish to proceed with (check all that apply):

   ☐ Dental implant(s)
   ☐ Tooth extraction(s)
   ☐ Socket graft
   ☐ Guided bone regeneration (GBR) with membrane
   ☐ Sinus graft
   ☐ Gum graft
   ☐ Gum surgery
   ☐ Same-day temporary crown or removable temporary tooth
   ☐ Full-arch treatment (fixed bridge on implants)
   ☐ Other: _____

   Teeth / sites: _____
3. **Alternatives.** My doctor has carefully examined my mouth and explained the alternatives, including no treatment, a removable partial denture, a fixed bridge on natural teeth, a complete denture, or an implant-supported denture. I have considered these alternatives and wish to proceed with the treatment checked above.
4. **Risks.** I have been informed of the possible risks and complications of surgery, drugs and anesthesia, including:

   - Pain, swelling, bruising, bleeding, infection and delayed healing; dry socket after an extraction
   - Prolonged or permanent numbness or altered sensation of the lip, tongue, chin, cheek, gums or teeth
   - Failure of an implant to fuse with the bone, or later loss of an implant, including from gum disease around the implant (peri-implantitis); a failed implant may need to be removed and replaced
   - Exposure or failure of a graft or membrane, which may require additional grafting
   - Sinus problems after a sinus graft or upper implant, including sinus infection or an opening into the sinus
   - Injury to neighboring teeth, crowns or fillings; jaw fracture; inflammation of a vein; allergic reactions to drugs or materials
   - A temporary crown or appliance breaking or coming loose
   - Cosmetic changes, especially in front teeth: gum recession, a visible gray margin, or spaces between teeth
   - Swallowing or inhaling a small instrument or part
   - Medication-related osteonecrosis (bone death) of the jaw in patients who take or have taken osteoporosis or cancer medications such as Fosamax, Boniva, Actonel, Reclast, Prolia or Xgeva, or who have had radiation to the head or neck
5. **If nothing is done,** I understand that any of the following could occur: bone disease, loss of bone, gum inflammation, infection, sensitivity, loosening of teeth followed by extraction, jaw joint (TMJ) problems, headaches, referred pain to the neck and facial muscles, and tired chewing muscles.
6. My doctor has explained that there is no method to accurately predict gum and bone healing in each patient following surgery.
7. I understand that in some instances implants fail and must be removed. The practice of dentistry is not an exact science, and no guarantee can be made about how my body will heal or respond to treatment. Smile Design Center's 5-year warranty on implants and restorations is provided separately in writing. **I should request the written warranty before treatment is started.** The warranty is conditioned on: professional

cleanings every 6 months; x-rays of my implants every year; and Dr. Bondar's continued ownership of Smile Design Center.

8. I understand that smoking or vaping, alcohol, uncontrolled diabetes, teeth grinding or clenching, poor oral hygiene, osteoporosis medications and radiation therapy may affect healing and limit the success of treatment. I agree to follow my doctor's home care instructions and to return for examinations as instructed.
9. I agree to the type of anesthesia chosen by my doctor. I will not drive or operate hazardous equipment while taking prescribed pain or anti-anxiety medication. If I receive anti-anxiety medication or sedation, I will arrange for a responsible adult to drive me home. I agree to take antibiotics as prescribed.
10. To my knowledge I have given an accurate report of my physical and mental health history, including all medications (especially blood thinners and osteoporosis or cancer medications), prior allergic or unusual reactions to drugs including anesthetics, blood or bleeding disorders, gum or skin reactions, and any other conditions related to my health.
11. I request and authorize the treatment checked above. I understand that during or after treatment, conditions may become apparent that, in my doctor's judgment, call for additional or different treatment for the success of my care. I approve such changes in design, materials or care if they are in my best interest. I understand that additional procedures may involve additional fees, as listed in my treatment plan.
12. I consent to photographs, x-rays and video of my treatment for my dental record and for professional education, provided my identity is not revealed. Use on the practice website, social media or advertising requires the separate Photo Release. ☐ I do not consent to photos for professional education.
13. **I have read this form, had the opportunity to ask questions, and all my questions have been answered to my satisfaction.**

Patient name (print)	Patient signature	Date
Parent / legal guardian (if applicable)	Relationship to patient	Date
Witness signature	Witness name (print)	Date
Doctor signature	Vitali Bondar, DDS	Date

SMILE DESIGN CENTER

Photo Release and Authorization

For use of patient photos on our website, social media and advertising

Patient name: _____ Date of birth: _____

Smile Design Center would like to show examples of our work to future patients. With your permission, we may use photographs taken before, during and after your treatment on our website (yoursmiledesign.com), on our social media pages, and in printed or online advertising.

Please check what you allow:

- ☐ Photos of my teeth and smile only, with my face cropped out
- ☐ Photos that show my full face
- ☐ Video of my treatment or results
- ☐ My first name with the photos
- ☐ Short testimonial or quote from me
- ☐ **I do not authorize any use of my photos for these purposes.**

I understand that:

- Signing this release is voluntary. It is not a condition of my treatment, payment or eligibility for care.
- I will not receive payment or other compensation for the use of my photos.
- I may revoke this authorization at any time by writing to Smile Design Center. Revoking it stops future use, but cannot recall materials already printed or published.
- Once photos are posted publicly, they may be viewed, copied or shared by others and may no longer be protected by privacy laws.
- I am entitled to a copy of this signed form.

This authorization expires: ☐ when I revoke it in writing ☐ on this date: _____

_____	_____	_____
Patient name (print)	Patient signature	Date
_____	_____	_____
Parent / legal guardian (if applicable)	Relationship to patient	Date