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## **INFORMED CONSENT AND PATIENT INFORMATION FOR IMPLANT THERAPY**

### ***EXAMINATION AND DIAGNOSIS:***

After an examination and detailed analysis of my mouth, my dentist has advised me that my missing tooth or teeth may be replaced with artificial teeth (a prosthesis) supported by and implant(s). I have been informed about and understand the purpose and nature of the oral implant treatment and any other anticipated treatment options that may be required.

### ***IMPLANT SUCCESS:***

It has been explained to me that implant(s) are not 100% successful, and that there is no method to predict healing capabilities in each patient. I understand that the success or failure of my implant(s) will determine the final design of the restorations(s) placed in my mouth.

It has been explained to me that in some instances implant(s) fail and must be removed. Likewise, implants which cannot be restored may be left unused.

I have been informed and understand that no guarantees or warranties as to the outcome of results of treatment or surgery can be made.

I also understand that smoking may decrease the chance of implant success, and that I must follow the home care instructions I am given at each stage of treatment.

I understand that I must schedule and attend regular follow-up examinations as instructed by all dentists involved in my implant treatment.

### ***TREATMENT:***

In order to treat my condition, my dentist has recommended the use of dental implant(s). I understand that the procedure for implant(s) involves placing implant(s) into the jawbone, and that implant therapy has a surgical phase followed by a prosthetic phase.

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**I.**

***SURGICAL PHASE OF PROCEDURE:***

I understand that general anesthetic or sedative drugs may be utilized and that I cannot operate a motor vehicle or hazardous device for at least three (3) hours – or time specified by practitioner after the administration of such drugs or anesthesia.

I understand that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone and implant(s) will be placed into the site(s) that have been prepared in my jawbone.

The gum will be closed over or around the implant(s) and a dressing may be placed. Healing will normally take four to ten months. I understand that denture(s) usually cannot be worn during the first one or two weeks of the healing phase and then must be modified and maintained during implant healing.

Some implant(s) require a second surgical procedure in which the overlying gum tissues will be opened and the stability of the implant will be assessed. If the implant appears satisfactory, an attachment (abutment) will be connected to the implant. After this second surgery, I may need to wait another one to two weeks before wearing my denture(s).

The procedures to create implant prosthesis (crown, bridge, or denture) can then begin. The prosthetic (restorative) phase of my treatment will take place over a series of several appointments after the second-stage surgery.

I further understand that if clinical conditions during surgery turn out to be unfavorable for the use of this implant system, or prevent the placement of implant(s), the dentist providing the surgery will make a professional judgment on the management of the situation, based on previous consultations with the restorative dentist and me. I understand that alternative treatment options may involve an additional surgical appointment to build up the ridge of my jaw with supplemental bone grafts or other types of grafts to assist in the placement, closure and security or stability of my implant(s).

**II.**

***PROSTHETIC PHASE OF PROCEDURE:***

I understand that at this point, I may be referred back to my dentist, to another dentist trained in implant therapy or to a prosthodontist (specialist in prosthetic dentistry). This treatment is as critical as the surgical phase for the long term success of the oral reconstruction of my mouth. During this phase, implant prosthesis (e.g. denture, crown or bridge) will be attached to the implant(s).

***ALTERNATIVES TO IMPLANT(S):***

I have considered the following alternatives to implant treatment:

1. No treatment
2. Construction of a conventional complete or partial denture(s), and/or
3. Tooth replacement with conventional bridgework using my remaining teeth (if possible).

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Alternatives to implant(s) have been explained. I have tried or considered these methods, but I desire an implant to help secure the replacements for the missing teeth.

***RISKS OF IMPLANT TREATMENT:***

I understand that the exact duration of the complications may not be determinable and may be irreversible (permanent).

I understand that failing implant(s) may require additional surgical procedures or even surgical removal, and may require additional prosthetic procedures or even subsequent placement of additional implant(s).

I understand that the surgical risks include, but are not limited to: pain; swelling; bruising; infection; bleeding; injury to neighboring or adjacent teeth; adverse drug reactions; discomfort; temporary or permanent damage to the nerves that give sensation to the lower jaw and lip which could result in numbness, tingling, burning, or pain of the affected area; jawbone fracture; jaw joint injury; delayed healing; sinus injury; irritation or infection; loss of one or more implants; and an ongoing risk of jaw fractures in very thin jaws. There are also risks associated with grafted and guided tissue procedures which include, but are not limited to: graft site problems (pain, swelling, bruising, bleeding, discomfort, infection, nerve injury, fracture); loss of the grafted tissue; rejection of bone or grafted material; separation of the wounds; abnormal healing of the site leading to a non-healing or compromised healing situation.

I also understand that there are certain inherent and potential risks in any treatment or procedure, that such complications may require additional treatment and that in this specific procedure the risks of surgery and anesthesia include, but are not limited to:

- A. Post operative swelling, disability and pain that may require sustained hospitalization or home recuperation, including stiffening and dysfunction of the facial, jaw and neck muscles.
- B. Stiffness of the jaw muscles and jaw joints (TMJ) causing prolonged discomfort and/or decreased chewing function. Pre-existing TMJ symptoms may be worsened especially during the incorporation phase.
- C. Prolonged or heavy bleeding, formation of a hematoma (blood clot) at the surgery site or in the floor of the mouth and bruising of the chin and lips, any of which may require additional treatment.
- D. Infection requiring additional treatment or possible removal of the Ankylos Implant.
- E. Stretching and scuffing of the corners of the mouth and lips.
- F. Terminating the surgical procedure due to anticipated lack of sufficient width of bone at the implant sites.
- G. Possible injury to sensory nerves of the face and mouth which may cause prolonged temporary – or on occasions permanent – numbness, tingling, or unpleasant sensations of the chin, lip, gum, jaws, face or tongue.
- H. Fracture of the jaw which requires further surgical procedures including bone grafts to stabilize the broken jaw. I understand that I must protect my jaw during yawning and avoid chewing forces on the lower jaw during the incorporation phase as discussed.

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- I. Failure of the implant requiring removal of part or all of the implant at any time after surgery. Failure may include fracture of components including posts or loss of bone adaptation about the implant at any time following surgery or placement of the denture requiring further surgery to attempt repair or removal of the Ankylos Implant.
- J. Complications around implant posts or screws or fracture of Ankylos Implant components that require corrective surgery in an attempt to salvage a failing implant may require another incorporation period without the lower denture for at least three months or more to allow proper bony healing.
- K. I understand that there will be apparent changes in facial appearance resulting from changes in muscle position. I have been advised and acknowledge that there is no guarantee that the procedure will improve my appearance. Patients react differently depending on several factors including outcome expectations. A good cosmetic result is intended but cannot be guaranteed.
- L. Complications of local, sedative and general anesthetic agents:
  - a. Allergic reactions
  - b. Nausea and vomiting
  - c. Inflammation, infection or bruising at the injection site
  - d. Headache and dizziness
  - e. Life-threatening reactions including heart irregularities, heart attack, stroke, brain damage or death.
- M. I have been advised that there is the possibility of temporary, or in very rare occasions permanent, damage to the nerves that control the muscles of the face or decreased function of the facial muscles resulting in some instances loss of facial tone or function.
- N. I also understand that, during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alternation of the planned procedure other than agreed herein. I therefore authorize and request that Dr. Jeffrey L. Davidson/ Dr. Bryan D. Tuttle and his associates or assistants under his direction perform such procedure as eventually found necessary and administer such drugs and other treatment as desirable in their professional judgment.
- O. I understand that anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance, that such effect is increased by use of alcohol, and that I must not operate any motor vehicle or other hazardous equipment while taking such drugs. Further, I agree not to operate any motor vehicle or other hazardous equipment for at least 48 hours after my release from anesthesia and surgery.
- P. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there exists a risk of failure, relapses, necessity for the retreatment or additional treatment, or worsening of my condition despite appropriate care. Additional expenses may be incurred if corrective procedures are required. I have also been informed that any implant exposed to the oral environment, like teeth, requires meticulous daily oral hygiene and that my failure to comply can in itself lead to failure of the Ankylos Implant. I understand my required postoperative responsibilities including a “no chew” diet and no smoking during the incorporation period of at least three months.

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I understand that prosthetic risks include, but are not limited to: immediate or delayed failure of an implant; fracture of the restoration(s) and/or implant components; wear of the restoration requiring a remake; difficulties with speech and /or chewing; and compromised esthetic or functional outcome as a result of implant loss or less than ideal angulations or position of the implant(s).

Unusual angulation or positioning of the implant(s) may necessitate either more complex, and therefore more expensive, prosthetic and/or endodontic treatment than what has been planned, or may possibly result in one or more of the implant(s) not being used to retain the prostheses.

I have been informed, and I understand, that if I choose not to treat my condition with implant(s) that the following risks are possible:

1. Continuing use of removable, complete or partial denture(s) with associated potential for discomfort and shrinkage of the jawbone which could necessitate relining of the existing denture or fabrication of a new denture;
2. Shifting of the neighboring teeth or over-eruption of the opposing teeth, increasing the possibility of gum and chewing problems;
3. Heavy bite forces on the remaining teeth, possibly leading to tooth fracture and/or loss; and/or
4. Shrinkage of bone on the lower jaw may make the nerves to the lower lip more susceptible to injury from pressure of a conventional denture.

***NO GUARANTEE:***

No guarantee or warranty has been made to me that the proposed implant treatment will be 100% successful or that the final restoration(s) will be totally successful from a functional or appearance standpoint. I understand that no medical or dental treatment is totally predictable and that this includes treatment with dental implant(s). I understand that because of unknown or unforeseen factors, further surgical or prosthetic procedures beyond those described to me might be necessary and that the final fee for treatment may therefore be more than the estimate I have been given. I also understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene procedures as directed and that I return for scheduled follow-up and recall appointments. I understand that there will be additional ongoing fees for these required procedures to maintain the health and function of my implant restoration(s).

***PUBLICATIONS OF RECORDS:***

I understand that photographs, slides, radiographs (x-rays) or any other viewing of my care and treatment during or after its completion may be used in publications or presentations. My identity, however, will not be revealed without my permission.

***RETREATMENT:***

I understand that I will attend for prescribed follow-up appointments and follow the home care instructions given to me following the placement of implant(s). It has also been explained to me that once the implant(s) are placed, the entire dental treatment plan, including personal oral hygiene and care, must be followed and completed on schedule as recommended. Any retreatment or additional treatment that may be considered necessary due to implant or prosthetic complications within one (1) year of placement will be handled as follows:

**Initial \_\_\_\_\_ Date: \_\_\_\_\_**

1. I will not be charged for clinical services to replace the implant(s) and/or repair, or replace the prosthesis. However, I will incur costs related to components and laboratory costs for materials. I will be given an estimate of the anticipated fees before retreatment begins. I understand that this does not constitute a warranty, but rather a statement of services.

Failure to follow prescribed home care procedures or attend follow-up appointments will mean that I will assume all costs for any retreatment required. In put and estimates for both the surgical and prosthetic aspects of required retreatment will be provided.

2. Beyond one (1) year following placement of the prostheses, I will assume all costs for any necessary retreatment due to implant or prosthetic failure. I will be given an estimate of anticipated fees before further treatment begins.

I understand that the above statement of services applies only to the clinicians involved in the original treatment involving the placement of implant(s) and prosthetics.

***PHYSICAL AND HEALTH HISTORY:***

To my knowledge, I have given an accurate report of my physical and mental health history and current condition. I have reported any allergies, illnesses, diseases, and any other conditions related to my health.

***FINANCIAL:***

***IMPLANT BODY PLACEMENT:***

I, understand all of the charges and I agree to pay ½ of the cost of the implant body placement (\$841.00. per tooth) to hold my appointment date and time. The price of pano co-pay is due on date records/pano/impressions, etc. are taken. The remaining balance for the implant body placement (\$841.00.00 per tooth) will be due at completion of service (s).

***IMPLANT CROWN:***

If you have Dental Insurance as a courtesy we will submit a Pre-Authorization to them to verify coverage for the implant crown. Insurance Companies rarely covers this procedure. If this is not a covered benefit or have no Dental Insurance the total cost of the implant crown (\$1500.00 per tooth) will be due on the day of surgery.

***CANCELLATION POLICY:***

I understand I need to provide 48 hours cancellation prior to my appointment surgery date to avoid a cancellation charge in the amount of \$300.00.

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**CONSENT:**

I read and understand English, and I have read and understand all of the information on this form.

I have had the opportunity to ask question, and have my questions answered to my satisfaction.

I, the undersigned, hereby consent to the performing of surgical and prosthetic procedures needed to place, restore and maintain my implant(s) including the use of anesthetics and sedation as indicated. The above treatment including the associated risks has been explained to me along with the alternatives.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness  
(If the patient is unable to sign,  
Or is a minor, parent or legally  
Authorized representative may sign)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of Surgical Dentist

\_\_\_\_\_  
Today's Date

**NOTE: A separate fee agreement must be signed, particularly if a legally authorized representative is giving consent on behalf of the patient.**

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