

PERIO, PLLC

Dr. John M. Remien DDS, MS

Consent for Root Form Dental Implants

Our practice is committed to providing our patients with the finest care possible. This includes informing you of the positive and negative possibilities of treatment as well as alternatives. We are guided by our obligation to you and the ethical standards of our profession which require written informed consent signed by the patient.

Specific Points Related to Root Form Dental Implants

- (1) **Diagnosis:** After a careful oral examination and study of my dental condition, my periodontist has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by a dental implant or implants.
- (2) **Recommended Treatment:** In order to treat this condition, my periodontist has recommended the use of root form dental implants. I understand that the procedure for root form implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.
- (3) **Surgical Phase of the Procedure:** I understand that sedation may be utilized and that local anesthetic will be administered to me as part of the treatment. My venous blood may be drawn, with my permission, and processed on site to provide additional material (PRP) to assist with the healing process. My gum tissue will be opened to expose the bone. Implants will be placed by tapping or threading them into chambers that have been drilled in my jawbone. The implants will be snugly fitted and held in place during the healing process.

The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of six weeks to six months. I understand that dentures often cannot be worn during the first one to two week of the healing phase.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my periodontist will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of the jaw and thereby to assist in placement, closure, and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Procedures to create an implant prosthetic appliance can then begin.

- (4) **Prosthetic Procedures:** I understand that at this point I will be referred back to my dentist or to a dentist who provides such care. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase an implant prosthetic device will be attached to the implant. The procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.
- (5) **Expected Benefits:** The purpose of dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.
- (6) **Principal Risks and Complications:** I understand that a small number of patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the implant surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient,

but on occasion, permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some of the teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and may be irreversible.

- (7) **Bone Augmentation Surgery:** I understand that some situations require bone regeneration or augmentation procedures to allow implants to be placed or to improve the prognosis for implant success, either prior to or in conjunction with implant placement. This may include bone augmentation of the area of the ridge where the implants are planned or within the sinus space(s) of the upper jaw. Applicable procedures and material used have been described, where appropriate, to my satisfaction.

I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alteration made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

- (8) **Alternative to Suggested Treatment:** Alternative treatments for missing teeth include: (1) no treatment, (2) new removable appliances, and (3) other procedures- depending on the circumstances. However, continued wearing of ill-fitted and loose removable appliances can result in further damage to the bone and soft tissue of my mouth.
- (9) **Necessary Follow-Up Care and Self-Care:** I understand that it is important for me to continue to see my regular dentist. Implants, natural teeth and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my periodontist.
- (10) **No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or loss of implant(s).
- (11) **Publication of Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public, however, without my permission.

Patient's Statement of Consent

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of root form implant surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the use of alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions present the placement of implants, I also give my permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Patient's Signature (or Parent/Guardian) _____ ~ Date _____