Consent Form: Surgical Insertion of Dental Implants

Dental implants are used as a basis for oral rehabilitation in patients who are missing one tooth or more. The insertion of a dental implant is a surgical procedure performed under local anesthesia.

Name of patient: _____
Last Name First Name I.D.

I hereby declare and confirm that I received detailed verbal explanation from:
Dr. _____
Last name First Name

about the treatment which will be provided to me using dental implants in the upper and/or lower jaw.
Details of treatment (type, location and quantity):

_____
_____
_____ (hereinafter: the "Principal Treatment").

I have been informed of the treatment necessary for the insertion of the dental implants, including the expected results and possible alternative treatments under the circumstances of the case. I considered the alternative treatments before choosing the dental implants insertion treatment. I have also been informed of the side effects of the Principal Treatment, including: swelling, pain, and subcutaneous hemorrhages. Furthermore, I have been informed of the risks and complications related to the Principal Treatment, including: Infection, injury to the mandibular nerve during implantations in the lower jaw, i.e. temporary or permanent loss of sensation in the lip and/or chin and possible injury to the upper jaw sinus (maxillary) during implantation in the upper jaw. I have been explained that implant absorption might fail and I am aware that in the event of non-absorption of the implant, it might become necessary to remove it and/or to perform a corrective treatment. It has been further explained to me that the manner and duration of the recovery of the bone and gums following insertion of dental implants are individual and unpredictable and that recovery might take 2 weeks.

It has also been explained me, and I understand the importance of continuing at the same place of treatment and of cooperation between the doctor performing the dental implant insertion and the doctor performing the rehabilitative treatment, and I am well aware that the treating staff/doctor will not be responsible for the treatment and its consequences if I decide at my own initiative to seek treatment of the implant and surrounding tissues with other clinic/s and/or dentist, against the advice of the treating staff.

I understand the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff/doctor, including maintaining oral hygiene, and receiving all necessary operative and prosthetic treatments and attending follow-up checkups on schedule as necessary

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after I received an explanation of the risks and complications of anesthesia including impaired sensation in the lip or in the tongue, hematoma, swelling and temporary limitation in opening my mouth.

Should the Principal Treatment be performed under general anesthesia, the information about the anesthesia will be provided to me by an anesthetist.

_____
Date Patient's Signature

_____
Name of Guardian (relationship) Guardian's signature
(when patient is legally incompetent,
a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian* all the aforementioned in detail as required and that he/she signed before me, after I satisfied myself that he/she fully understood my explanation.

_____ _____ _____
Name of Physician Signature License No.

* delete if inappropriate

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