



**Mission Valley
Oral & Maxillofacial Surgery, Inc.**

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2878 Camino del Rio South • Suite 210
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619/ 298-2200 • Fax: 619/ 298-2250

CONSENT FOR TWO-STAGE OSSEOINTEGRATED IMPLANT SURGERY

You have the right to be given information about your proposed implant placement so that you are able to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is your acknowledgment that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

____ Patient's Name

____ Date

____ 1. I hereby authorize Dr. _____ and assistants to treat the condition described as: _____

____ 2. The procedure offered to treat the condition has been explained to me and I understand the nature of the procedure to be: _____

____ 3. I understand that incisions will be made inside my mouth for the purpose of placing one or more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge or denture that will later be attached to this implant(s) will be made and attached by _____ and that a separate charge will be made by his/her office.

____ 4. I understand that the implant(s) may remain covered by gum tissue for at least three months before being used and that a second surgical procedure may be required to uncover the top of the implant. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted, the entire treatment





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SURGERY CONT.**

plan must be followed and completed on schedule. If the planned schedule is not carried out, the implant(s) may fail. Long term success of your implant will be dependent on continued close follow up care with your dentist.

____ 5. I have been informed of possible alternative methods of treatment (if any), including: _____

I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

____ 6. My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:

- A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
- B. Prolonged or heavy bleeding that may require additional treatment.
- C. Injury or damage to adjacent teeth or roots of adjacent teeth.
- D. Post-operative infection that may require additional treatment.
- E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
- F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
- G. Injury to nerve branches in the lower jaw resulting in numbness, pain or tingling of the chin, lips, cheek, gums or tongue on the operated side(s). These symptoms may persist for several weeks, months or, in rare instances, may be permanent.
- H. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally entered (sinus-lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medications and additional recovery time.





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- I. Fracture of the jaw or perforation of thin bony plates.
- J. Use of other materials which may have to be removed at a later date
- K. Bone loss around implants
- L. Implant or prosthesis fracture, or loss of the implant due to rejection by the body.
- M. Other: _____

___ 7. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from that set forth in paragraph 2 above or addition of a different doctor. I authorize my doctor and his staff to perform such additional procedures as are necessary and desirable in the exercise of professional judgment.

___ 8. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment.

INFORMATION FOR FEMALE PATIENTS

___ 9. I have informed my doctor if I use birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.

___/___

Yes No I have been given written preoperative instructions to follow before my surgery and these have been reviewed with me to my satisfaction

___/___

Yes No I have been given written postoperative instructions to follow after my surgery and these have been reviewed with me to my satisfaction





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CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

BEFORE SIGNING, PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

Patient's (or Legal Guardian's) Signature Date

Translator's Signature Date

Doctor's Signature Date

Witness' Signature Date

I have been advised that my surgery will not be performed by Dr. _____, but by Dr. _____ and I give my consent for this change in providers.

Patient's (or Legal Guardian's) Signature Date

