deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR DENTAL IMPLANTS

PATIENT NAME_____DATE_____TOOTH #_____

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

DIAGNOSIS: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

TYPE OF IMPLANT: Implant(s) to be used on me is one which is placed into the jawbone; this is done reflecting a flap of gum, preparing a site in the bone, then inserting the implant into the bone and finally covering the bone and implant with gum flap.

SURGICAL PROCEDURES: I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site, either prior to implant placement or after the implant(s) have healed. I also understand that sometimes the implant is covered with a bone graft material or membrane to further enhance healing and that this may necessitate an additional procedure.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may modify or change from the original plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to the performance of such additional or alternative procedures as may be required by proper dental care in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect gum healing and may limit the successful outcome of the implant(s). I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as instructed.

RESPONSIBILITY FOR PROSTHETIC SUCCESS: I understand that the fabrication and attachment of prosthetic devices (attachment and tooth replacements) will be the responsibility of another dentist and that the

***Initial here*_____**

32241 Crown Valley Parkway, Suite 250 ●Monarch Beach, CA 92629
Telephone: (949) 248-3848 ● Fax: (844)272-1012 ● Email: RuprechtDDS@gmail.com
www. orangecountyperiodontist.com

long-term maintenance, repair and success of these devices will be the sole responsibility of the dentist who provides this prosthetic care.

SUPPLEMENTAL RECORDS AND THERE USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed or any other reasonable alternative treatment that such a decision is my sole responsibility. I ac knowledge that the risks related to my non-acceptance of treatment for may problem have been explained to me and include but are not limited to: dissatisfaction with or failure of other forms of tooth replacement, further deterioration of jaw bone, further gum recession, problems with my bite including pain, spasm, headaches or problems with my jaw joints are associated musculature.

RISKS RELATED TO THE SUGGESTED TREATEMENT: Risks related to the surgery include but are not limited to the post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, upper jaw sinus or nasal cavity perforation during the surgery, transient or on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasm, bone fractures and slow healing. Prosthetic risks include but are not limited to unsuccessful union of the implant(s) to the jaw bone, stress metal fracture of the implant(s). If any of these occur, a separate surgical procedure would be necessary to remove the failed implant(s). Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing or foreign matter, facial swelling or bruising, pain, soreness, or discoloration or blockage along a vein at the injection site.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed implant(s) will be completely successful in function and appearance (to my complete satisfaction.) It is anticipated (hoped) that the implant(s) will be permanently retained but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long term success cannot be promised.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all, procedures related to the implant procedure as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

_____	_____
Signature of Patient, Parent or Guardian	Date
_____	_____
Printed Name of Patient	Relationship to patient
_____	_____
Signature of Witness	Date
_____	_____
Printed Name of Witness	Date

32241 Crown Valley Parkway, Suite 250 ●Monarch Beach, CA 92629
Telephone: (949) 248-3848 ● Fax: (844)272-1012 ● Email: RuprechtDDS@gmail.com
www. orangecountyperiodontist.com