HALFMOON FAMILY DENTAL

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CONSENT FOR IMPLANT SURGERY

I hereby authorize Dr. ______________________ to perform implant surgery upon ______________________ (name of patient). I have been informed that the purpose of the operation is to surgically place a dental implant(s), into the supporting jawbones. In the event that extraction of an implant is deemed advisable by Dr. ______________________ due to conditions visualized and determined at the time of surgery, I hereby consent to all such extractions.

If any unforeseen condition should arise in the course of the operation, calling for Dr. ______________________'s judgment or for procedures in addition to or different from those now contemplated, I further request and authorize the Doctor to do whatever he may deem advisable. Further, I have been informed of other possible alternatives and/or supplemental methods of treatment, if any.

Post-operative risks of the proposed surgery include, but are not limited to; pain, restricted mouth opening for several days, weeks, or longer; parasthesia (numbness) of the jaw or gum nerves which may persist for several weeks, months, or in remote instances permanently, gum recession (shrinkage); temporary, or, in rare instances, permanent interference with phonetics (speech sounds); clicking or pain of the temporomandibular joints (jaw joints) tooth sensitivity to hot or cold for days, weeks, or on occasion, several months; transient or in some instances permanent tooth mobility (looseness) in selected areas; food lodging between the teeth after meals, requiring cleaning devices such as floss for removal; and unaesthetic exposure of crown margins of teeth in the surgery area.

I further understand that if no treatment is rendered, my present condition will probably worsen in time.

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the best of care. However, it is Dr. ______________________'s opinion that therapy will be helpful, and that any further loss of supporting tissues or bon would occur sooner without recommended treatment.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance visits (recall professional care).

I consent to photographs of my oral and facial structures and their publications for educational and scientific purposes.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT AND THE EXPLANATION REFERRED TO OR

MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I READ AND WRITE ENGLISH.

Dentist Signature	Patient Signature
Witness Signature	Witness Signature
Parent of Guardian Signature if Patient is a Minor	Date