INFORMED CONSENT

I have been made aware of my present condition. I have been made aware of the risks versus benefits of doing nothing as well as several treatment options. I am aware of the risk in restoring teeth with deep decay. I am aware that cigarette smoking is hazardous to my health and compromises healing after any dental treatment. I am aware that the prognosis of restorative dental treatment depends on numerous factors including systemic factors, available bone, the number and condition of abutments, parafunctional habits, and post treatment care. I understand that removable prostheses may be unsatisfactory to me in the short term or the long term. I understand that removable prostheses may require a certain degree of patient adaptability and may feel somewhat unstable. Dental implants may be utilized to provide additional stability and retention. I understand that there are numerous factors which contribute to the success or failure of dental implants. Due to the established negative relationship between cigarette smoking, healing of bone graft and dental implant success, I understand that no implants will be surgically placed unless I have not smoked for at least one month.

I request and authorize ***Dr. Soni DDS***, and whomever he may designate as his assistant, to perform the above listed procedures as well as any others that he may deem advisable if any unforeseen conditions arise in the course of these designated operations and/or procedures calling, in his judgment, for procedures in addition to or different from those contemplated.

I consent to the above treatment after being advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment is withheld. I had the opportunity to watch dental implant videos and / or pictures chair side in the clinic.

I consent to the above treatment plan after being advised of the alternative plans of treatment available and the known material risks, advantages and disadvantages of alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. These risks include adverse drug response (e.g., allergies or allergic reaction), cardiac arrest, aspiration, thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs.

I am informed and fully understand that, inherent in any type of surgery, there are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations.

Less common complications include infection, loss or injury of adjacent teeth and soft tissue, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure, and swallowing or aspiration of teeth or restorations or any type of material or elements used during the surgery, and small root fragments remaining in the jaw which might require extensive surgery for removal.

For surgical procedures involving lower arch – altered lip and tongue sensation such as itching, burning, tingling, paresthesia or anesthesia can occur. Usually the symptoms are short term lasting from few days to weeks, but can extend for longer periods with lack of sensation on lip or tongue. In rare instances it can result in permanent lip numbness. Based on evaluation further treatment recommendations will be made including referral to an appropriate Oral surgeon or nerve repair specialist.

For surgical procedures involving upper arch – a communication can occur between the oral cavity and the sinus. Implant while being placed in upper jaw can dislodge into the sinus. Retrieval of implant may require referral to an Oral surgeon.
I realize that even with these possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and food to which I am allergic or intolerant. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated treatment and procedures, prior to signing this form.

I have been made aware of the diagnosis associated with my condition and the proposed treatment options associated with this condition.

I have had the nature and purpose of such proposed treatment procedures explained to me and I understand the nature and purpose of these procedures.

I have had the material risks associated with the proposed treatment discussed with me and I recognize and accept these risks of treatment.

I have had the likelihood of success of the proposed treatment discussed with me and understand the likelihood of success and the prognosis associated with the proposed treatment.

I understand the practical alternatives to the proposed treatment and I have been encouraged to review the proposed treatment as well as alternative treatment options with other reasonable and prudent dentists and physicians.

I have been made aware of the prognosis of my condition if the proposed treatment or alternative acceptable treatment options are rejected.

*I give **Dr. Soni DDS**, or any person whom he assigns, permission to utilize photographs, video, or audio recordings for the purpose of education as well as for the advancement of the field of dentistry.*

_____ _____
Parent/Guardian type in your name in lieu of Signature Date

_____ _____
Witness Signature Date

Please download and save form, fill and Email it to info@greatlakesdental.net / Descargue y guarde el formulario, complételo y envíelo por correo electrónico a info@greatlakesdental.net