Dental Specialists Of Texas, P.A.
Compassionate Care with a Personal Touch
Hiru Mathur, D.D.S., M.S., Diplomate
15200 Southwest Freeway, Suite 120, Sugar Land, TX 77478
Phone: (281) 494-2477 Fax: (281) 494-2487

INFORMED CONSENT FORM FOR DENTAL IMPLANTS

Patient Name: _____

- **Consent:**

After a careful oral examination and study of my dental condition, Dr. Mathur has recommended dental implants as the best method to reconstruct my dentition. I have been fully informed of the nature of dental implants, the procedures involved, the associated benefits and risks of implant supported artificial teeth, and the alternative treatments available. I agree not to drive or operate heavy machinery for 24 hours after my surgery. I hereby declare it my wish to have the benefits of dental implants and I consent to their surgical placement in my jaw (s).

- **Surgical Phase Of Procedure:**

I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will be placed by pushing or threading them into holes that have been drilled in my jawbone. The implants will have to be snugly fitted and held tightly in place during the healing phase.

The soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be place. Healing will be allowed to proceed for a period of four to six months. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase.

I further understand that if during surgery, clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my periodontist will make a professional judgment on the management of the situation. The procedure may need to be cancelled or may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw to allow placement, gum closure, and security of my implants. I understand that additional charges may be incurred.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance or artificial crown can then begin.

- **Restorative Phase of Treatment:**

I understand that I will be referred back to my dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic device will be attached to the implant. This procedure should be preformed by a person trained in the prosthetic protocol for the root form implant system. The restorative dentistry (“the teeth”) is to be done by another dentist who has no affiliation with Dental Specialists Of Texas P.A./Dr. Mathur. There will be a substantial fee for the prosthesis (teeth). I understand that fees

for the restorative treatment done by another dentist are IN ADDITION TO the surgical fees.

- **Risks and complications:**

I have been informed and understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include pain, infection, swelling, and /or discoloration. Numbness of the lip, tongue, chin, cheeks, or teeth may also occur. The exact duration of these complications cannot be determined and they may be irreversible. Also possible are injury to the teeth, bone fractures, nasal and sinus penetrations, delayed healing and allergic reactions to drugs or medications used.

- **Benefits:**

The purpose of dental implants is to allow me to have more functional artificial teeth or improved appearance. I understand that the purpose of dental implants is to provide support, anchorage, and/or retention for artificial teeth. The artificial teeth attached to the implants will be essentially stationary and, depending upon design, will be removable by either me or my dentist.

- **Alternative Treatments:**

Alternative treatments for my edentulous (missing teeth) have been explained to me. These include no treatment, or new fixed or removable appliances. I also understand that continued wearing of ill fitting removable appliances can result in the further damage to the bone and soft tissue of my mouth.

- **Healing Capacity and Predictability:**

I have been informed there is no method of accurately predict or evaluate how much my gum and bone will heal. I do understand that the success of the implant can be affected by: systemic disease, dietary and nutrition problems, smoking, alcohol consumption, drug abuse, clenching and grinding of the teeth, and inadequate oral hygiene.

To my knowledge, I have reported to my dentist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical venture. I agree to follow the personal daily care as recommended by my dentist and my physician.

- **Further Complications:**

It has been explained to me that the connection between the implant and the bone may fail and it may become necessary to remove the implant. I understand that this can happen in the preliminary healing phase, or at any time thereafter. I further understand that there is no guarantee or assurance that the implant system and/or the artificial appliances will be completely successful in function or appearance (to my complete satisfaction). Because of the uniqueness of each patient and since the practice of dentistry is not an exact science, long term success cannot be guaranteed and the function, comfort, and appearance of the prosthesis may be less than what I hoped for.

- **The Proposed Implant System:**

I do agree that if clinical conditions are found to be unfavorable for the use of this implant system, and alternative system or method selected by my dentist can be substituted. If clinical conditions prevent the placement of implants, I defer to my dentist judgement on the surgical management of that situation.

- **Tampering With The Implant System or Prosthetic Appliance:**

I have been informed that the prosthetic appliance can be a big factor in the success or failure of the implant. I understand that alterations made on the artificial appliance or the implant by an uniformed person, (including myself), could possibly lead to ill effects, which would become the sole responsibility of said individual doing the alterations.

- **Necessary Follow-up Care and Self-Care:**

I understand that it is important for me to continue to see my general dentist or prosthodontist. Implants, natural teeth and appliances must be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my periodontist.

- **No Warranty Or Guarantee:**

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a therapist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants, despite the best care.

- **Publication Of Records:**

I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public however, without my permission.

PATIENT CONSENT

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during consultation and in the treatment plan presented to me. I also consent to use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to my periodontist's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and hereby to assist in placement and security of my implants.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND CONSENT TO THE FOLLOWING TREATMENT: _____

_____

_____ _____

Date (Printed Name of Patient, Parent, or Guardian)

_____

(Signature of Patient, Parent or Guardian)

_____ _____

Date (Signature of Witness)