Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Dental Implant Consent:

Patient Name: _____ Date: _____

Implant Placement and restoration involves two major stages: surgical placement of the implant(s) followed by the restoration of the implant after osseointegration occurs. (The bone grows around the implant.)

Please read through and initial all of the following:

____I understand that Dr. Douglas Sanchez, DMD. Will be placing the implants, extracting any existing tooth if necessary, and placing any bone and/or soft tissue grafting required. I understand this is often a two stage surgical procedure and a surgical informed consent discussion will take place.

____I understand that Dr. Douglas P. Sanchez, DMD. will be doing the restorative phase and any specific questions I have regarding the final restoration will be answered during the informed consent discussion.

The following information is an outline of the discussion Dr. Douglas Sanchez and I had regarding the implant procedure (s).

Current Condition:

____I have discussed and understand my current condition with Dr. Sanchez. I understand that a healthy mouth with sufficient bone mass is required for a successful implant. I understand I may require extractions, treatment of periodontal disease, as well as any root-canals, retreats, or crowns to be completed prior to implant surgery.

____I understand I may require bone augmentation, bone and/or soft-tissue grafts to be placed before, during or after the implant(s) are placed. I understand the placement of such materials is not inclusive in any arrangements I have made for the implant(s) unless otherwise stated.

Alternative Treatment Options:

____I have been informed and discussed all of the treatment options I have to replace missing teeth including: No replacement at all, removable (dentures or partial dentures), and fixed (bridge) appliances. I understand the benefits, risks, and contraindications of all the options given.

Facts for Consideration:

____Dental implants are metal anchors placed into the jawbone and underneath the gum tissue to support artificial teeth where natural teeth are missing. When the bone attaches itself to the implant,

the implant acts as a tooth root substitute and forms a strong foundation to stabilize the customized, artificial teeth.

____I understand that the placement of implants and the making of compatible restorations are two separate treatments with separate expenses as well as separate risks and benefits.

____I understand that in order for the implants to be placed in my bone my gum tissue will be opened to expose the bone. Implants will be placed by pushing or threading them into holes made in the bone. The implants will have to be snugly fitted and held tightly (torque) in place during the healing phase.

____I understand that the soft tissue will be sutured closed over or around the implants and that a periodontal dressing may be placed. Healing will be allowed to proceed for a period of three to nine months.

____I understand that for those types of implants that require a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be tested. If the implant appears satisfactory an attachment will be connected to the implant, and the restorative phase to create a prosthetic appliance or crown can begin.

____I understand that no specific estimate can be made regarding the period for the longevity and retention of the implant. If fixtures have to be removed I should be able to return to using a conventional or partial denture, or possibly have additional fixtures placed in the future. It has also been explained to me that once the implant is placed the entire treatment plan must be followed and completed on schedule. Failure to follow through with all instructions given will lead to a higher risk of the implant failure.

____I understand that additional maintenance and repair may be expected for the implants. I am responsible for all surgical costs and I further understand that there will be no refund of fees in the event of complications requiring additional surgery to salvage the implant or failure requiring the removal of all or part of the implant. Should removal be required the doctor will remove the implant at no additional cost. Should I choose to have someone else remove the implant I am responsible for the cost. I understand that further placement of bone or soft tissues grafts are separate from the removal of a failed implant.

____I understand that dentures or removable prostheses usually cannot be worn during the first one to two weeks of healing.

____I understand that the practice of dentistry I not an exact science. There are no guarantees or assurances regarding the outcome or results of treatment or surgery.

Risks and Benefits:

____ I understand short-term effects after surgery include: swelling, stiffness of the jaw muscles, bruising, bleeding, and moderate pain for 24 to 48 hours.

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____I am aware that although dental implants have a high rate of success, like all surgery it carries with it the possibility or complications not limited to the following:

- Swelling that worsens after 48 hours.
- Intense pain that cannot be relieved by prescription medication.
- Infection
- Permanent loss or alteration of nerve sensation resulting in numbness or tingling in the lip, tongue, cheek, chin, gums, or teeth.
- Sinus Complications.
- Excessive or prolonged bleeding.
- TMJ (temporomandibular jaw joint) pain or abnormal function of the jaw, jaw facture.
- Adjacent teeth, roots, fillings, or bridgework injuries or damaged.
- Bone loss around the implant.
- Implant failure (the bone does not grow around the implant).

____ I understand that if any of the above occurs I should immediately contact Dr. Sanchez.

____ I understand that smoking, excessive alcohol consumption and chewing hard foods such as ice or candy may result in damage to my implants and can cause them to fail completely.

____I understand that medical conditions can compromise the longevity of an implant.

____ I understand that I must keep my implants and prostheses clean by daily maintenance as well as regular check-ups at my dentist's office.

Drugs, Medications, and Anesthesia:

____I understand that failure to complete the course of antibiotics and/or to take any medications prescribed to me by Dr. Sanchez significantly increases the chance of implant failure.

____ I understand that antibiotics, pain medication, and other medications may cause adverse reactions which can be increased by the effect of alcohol or other drugs. Sometimes after the injection of anesthetic I may have prolonged numbness and/or irritation in the area of the injection. If I use Nitrous Oxide, Halcion, Xanax, Atarax, or any other sedatives may also have adverse reactions. I understand should I choose to use a sedative it will prescribed to me by Dr. Sanchez, DMD, filled at a pharmacy, and will require me to have a driver to and from my surgical implant appointment. I will not drive operate a motor vehicle or hazardous device for a minimum of 24 hours.

Patient Criteria:

____I understand the importance of providing my complete medical history to Dr. Douglas P Sanchez, DMD or any other doctors to be administering my treatment plan. I have reported any known medications, allergies, prior reactions to food, drugs or dental treatment, blood or body diseases, gum or skin condtions/reactions, abnormal bleeding, or any other conditions relating to my health.

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____ I understand that Dr. Douglas Sanchez DMD may decide to cancel the implant surgery once it is underway if I need supplemental bone grafts or other types of grafts to build up the ridge in order to allow placement, gum closure, and securing of the implants. It may even be discovered once the surgery is underway that I am not a candidate for implant treatment.

____ I understand that success requires my long-term oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, as well as periodic and regular follow-up appointments.

____There may be several follow-up clinical visits for the first year following surgery. Dr. Sanchez may want me to return for 1 week post-op appointments after the placement of the implants. I understand it is my responsibility to make these appointments, and to see the doctor at least twice a year after completion of the implant and restoration in order to evaluate implant performance and oral hygiene maintenance.

____ I will let the doctor's office know if I change my address or phone number(s) so I can be contacted for any recall appointments.

____ I understand Dr. Sanchez and/or staff members may need to take x-rays, and photos (intraoral and external) to monitor the progress of my implants and conditions.

Finance:

____ I know and understand the fees I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections, anesthetics or bone/soft-tissue grafts that may later be required to correct any complications. As a courtesy to me the office staff will help prepare and file insurance claims should I be insured. However the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company, and does not relieve my responsibility to pay for services rendered. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and/or deductibles at the time of service and all costs that have not been paid for by my insurance. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest (unless otherwise discussed with me), and I will be responsible for any collections costs should I not cover my portion.

Consent:

[ ] I have had my questions answered to my satisfaction. I consent to have Dr. Douglas P. Sanchez perform the oral surgery to place the necessary implants for my treatment. I authorize and direct Dr. Sanchez with his associates to do whatever is deemed necessary and advisable under the circumstances including not proceeding with the procedure once surgery is underway if I am found not to be a candidate for dental implants.

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[ ] I refuse to give my consent for Dr. Douglas P. Sanchez, DMD. to complete the described treatment and understand the potential consequences with this refusal.

X_____ Date: _____

Patient Signature

I, Dr. Douglas P. Sanchez DMD, attest that I have discussed the risks, benefits, consequences, and alternatives of implant surgery with my patient, who has had the opportunity to ask questions, and I believe that my patient understands what has been explained.

X_____ Date: _____

Dr. Douglas P. Sanchez, DMD Signature