GREAT • LAKES
ORAL & MAXILLOFACIAL
SURGERY CENTRE

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CONSENT FOR OSSEOINTEGRATED IMPLANTS

1) I hereby authorize Dr. Cameron Walker to perform surgery upon me, to insert a two stage endosteal osseointegrated implant in me upper/lower jaw.

2) I understand incision(s) will be made inside my mouth for the purpose of placing one or more endosteal metal root form structures in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown (cap), denture, or bridge. I acknowledge that Dr. Cameron Walker has explained the procedure, including the planned number and location of the implants(s) to be placed, in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant by Dr. _____ and the cost for that work is not included to the charge for this procedure.

I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be given.

I have been informed that the implant must remain covered under the gum tissue for at least three months before it can be used and that a second surgical procedure may be required to uncover the top of the implant.

It has also been explained to me that once the implant is inserted, the entire dental treatment-plan, including my personal oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.

I understand the limitations of implant-supported crowns/bridgework-specifically the quality and quantity of the bone ridge, in an anterior crown/bridge, esthetics can be compromised by the contour of the bony jaw ridge and gingival (gum) tissue.

3) I have been informed of the alternatives to use of osseointegrated implant. The advantages and disadvantages of these procedures have been explained to me and I choose to proceed with insertion of the osseointegrated implant.

4) I understand that there are normal sequellae (after effects) and possible complications associated with this procedure andthese have been explained to me. They may include, but are not limited to, facial/oral swelling; damage to other teeth, jaw bone, fillings or to other dental work; infection or abscess; pain; bleeding; sinus or nasal problems; injury to nerves near the treatment site which may cause numbness, tingling, or other alteration of sensation of the lips, chin, face, mouth teeth or tongue (which is usually temporary but may be permanent); opening of the sinus cavity located above the upper teeth.

I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that failure of this implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period.

5) I understand the costs involved with this treatment-plan and the limitations of dental/medical insurance for implantology treatment-plans, and I am agreeable to the estimate given and the payment schedule outline by the doctor/staff.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENT REQUIRING INSERTATION OR COMPLETION WERE FILLED IN AND ALSO STATE THAT I READ AND WRITE ENGLISH.

_____	_____	_____
Signature of witness	Patient signature (or Guardian)	Date
_____	_____	
Print name of witness	Print name of Patient (or Guardian)	

_____
Address of witness

I have had the opportunity to fully discuss with the patient the nature of the procedure/surgery and the inherent risks.

_____	_____
Doctor Signature	Date