BRIGHTON DENTAL
Implants. General Dentistry. Restorations. Surgical Referrals.

Brighton Dental P.L.C.
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IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the *implant surgery* procedure. I understand what is necessary to accomplish the placement of the *implant* under the gum or in the bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire implants to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications may include pain, swelling, infection, and discoloration and in rare instances death. Numbness of the lip, tongue, chin, cheek and teeth may occur. The exact duration may not be determinable and may be irreversible.
4. I understand that if nothing is done, any of the following could occur: *bone disease, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction*. Also possible are temporal mandibular joint (jaw), headaches, and referred pains to the back of the neck and facial muscles and tired muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand the practice of dentistry is not an exact science and that no guarantees or assurances as the outcomes of results of treatment or surgery can be made.
7. I understand that excessive smoking, alcohol or sugar, may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. I agree to the type of anesthesia, depending on the choice of my doctor. I agree not to operate a motor vehicle or any hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
9. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, pollens, dust, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

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Implant Patient Information and Consent Form continued…

11. I request and authorize of medical/dental services for me, including implants and other surgery. I fully understand that during the following the contemplated procedure, surgery, or treatment conditions may become apparent which warrant in the judgment of the doctor additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care, if it is felt this is in my best interest.

_____ _____

Signature of Doctor *Signature of Patient or Legal Guardian*

_____ _____

Date *Relationship to Patient*