### CONSENT TO TREATMENT FORM – DENTAL IMPLANTS

1. I authorize upon myself or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following procedure(s) and treatments:
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_ or whosoever he/she may designate to perform such treatment. I also consent to such additional or alternative procedures that may be found immediately necessary during the course of such procedures or treatment.

1. The nature of and purpose of the treatment, possible alternatives methods of treatment, the risks involved and the possible complications have been explained to me by Dr. \_\_\_\_\_\_\_\_\_\_\_as follows:

**ALTERNATIVES TO DENTAL IMPLANTS**:

Include, but are not limited to:

1. No treatment,
2. A removable cast or acrylic partial denture,
3. A fixed partial denture like a bridge, and
4. Mini implants, sub-periosteal implants or other types of implant devices.

**POSSIBLE COMPLICATIONS**: which have been discussed with me include, but are not limited to:

1. pain and swelling,
2. bleeding,
3. infection,
4. failure of the implants to osseointegrate
5. injury to adjacent teeth or fillings,
6. unusual reactions to medications given or prescribed,
7. fracture of the jaw, and
8. trismus – limited jaw opening.
9. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.
10. I consent to the administration of such anesthetics and pain medications as may be considered necessary or advisable by Dr. \_\_\_\_\_\_\_\_\_\_ or their team.
11. I agree to co-operate completely with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and their team, and will follow postoperative instructions to the best of my ability for my own comfort and safety. I will be available to any follow-up appointments and will attend regular recall appointments. I have had the opportunity to ask questions concerning these procedures.

I Certify that I have read and fully understand the above consent to treatment and that the explanations herein referred to were in fact made to me and that the form was filled in prior to treatment. I represent that I am eighteen (18) years of age or over and have read and understood the foregoing and I agree to be bound thereby.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (In my opinion, the patient appears to understand the treatment proposed.)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_