STUART CENTER
FOR LASER PERIODONTICS & IMPLANTS
Committed to your success

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PLEASE READ, REVIEW AND BRING WITH YOU.

The International Congress of Oral Implantologists
IMPLANT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and 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 and in the bone.
2. Dr. DeTure has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant 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 include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medication used, etc. In some cases it is not possible to place implants initially because of inadequate bone or other anatomy. In these situations bone grafting may be required, necessitating additional procedures and costs.
4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, loss of additional teeth. Also possible are temporo mandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
5. Dr. DeTure has explained that there is no method to accurately predict the gum and the gum healing capabilities in each patient following the placement of the implant. Implants are usually uncovered 4-6 months after placement using minor surgical procedure and then the crown or bridges are placed on top of the implants by your regular dentist.
   Occasionally if the added bone is excellent, no second stage surgery to uncover is needed.
6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment or surgery can be made. If implants fail within the first 5 years after placement, they will be removed at no charge and replaced if indicated at one-half off the fee. In order for this guarantee to remain in effect you must follow our recommended recall schedule. If you are not seen in our office for maintenance, we recommend seeing you yearly for implant maintenance in addition to your regular maintenance. Smoking during care will nullify the warranty.
7. I understand that smoking, alcohol, diabetes and other systemic diseases 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 Dr. DeTure. I agree not to operate a motor vehicle or 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 history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthesia, pollens, dust, blood or body diseases, 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.
11. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and 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 modification in design, materials, or care, if it is felt this is for my best interest.

_____	_____
Signature of Dr. DeTure	**Print & Signature of Patient or parent/legal guardian**
_____	_____
Witness	**Implant site**
_____	_____
Date	**Relationship to Patient**