Kurt E. Delius, D.D.S., M.S.
Periodontics and Dental Implants

REQUEST AND CONSENT FOR DENTAL IMPLANTS

I request and authorize Dr. Kurt E. Delius, and whomever he designates as his assistants to perform the following treatment/procedure(s) for:

Name of Patient: _____

Description of Patient's Condition/Problem Being Treated: _____

Description of Treatment/Procedure(s): _____

NATURE AND PURPOSE: I understand that incisions will be made in my mouth for the purpose of placing one or more metal structures in my jaw(s) to serve as anchor(s) for a missing tooth or teeth or to stabilize a crown, denture, or bridge. I understand that this implant should last for many years, but that no guarantee that it will last for any specific period or time can be or has been 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. I have had explained to me, and I have had sufficient opportunity to discuss my/the patient's dental condition, the treatment procedure(s), and the benefits to be reasonably expected from this treatment. I further authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by Dr. Kurt E. Delius to diagnose and/or treat my/the dental condition(s).

ALTERNATIVES: The alternatives to the proposed treatment/procedure(s) have been discussed with me to include but not limited to; no treatment or restoration with other types of dental prosthesis. Alternatives have been explained to me with advantages and disadvantages and I choose to proceed with insertion of dental implant(s).

RISKS: The usual and most frequent risks and complications related to the planned treatment/procedure have been explained to me. These risks include but are not limited to: the possibility of pain or discomfort during and following treatment, gum recession, bruising, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporary or permanent numbness, allergic reactions. Due to the closeness of the nerves to the planned implant site(s), it is possible to bruise or damage a nerve during the insertion of the implants. Numbness or altered sensation of the tongue, lips, skin, or teeth may result. In the upper jaw, it is possible to create an opening into the sinus. In some cases, this may cause sinus problems requiring additional treatment or loss of the implant during treatment, unforeseen complications may be discovered which proper surgical procedure dictates should be treated at that time. I therefore consent to the performance of such additional or alternative procedures as may be indicated by proper surgical care. This may include but is not limited to grafting of bone to allow placement of the implant(s) or not placing the dental implant(s) if a suitable site is not available.

NO WARRANTY: I have been informed that the long term success of treatment requires my cooperation including daily oral hygiene to control plaque as well as regular periodic recall visits upon completion of the proposed treatment/procedure. I understand that there is always the risk of treatment failure. Although we have chosen scientifically proven devices, there is a failure rate with all such implants. A failure may result in inability to complete the treatment as planned as discussed. Failure may result in bone loss requiring no treatment, or grafting procedures. A failure may be able to be resolved by placement of future implants some months later, or result in implants not being a method available for treatment. I acknowledge that no guarantees have been given to me regarding the results of treatment, or whether it will be curative and/or successful to my complete satisfaction.

I have been advised that prescribed medications may cause drowsiness and lack of awareness and coordination. Because of this, I understand that it is not advisable to operate any vehicle, automobile, or hazardous device until fully recovered from their effects.

WOMEN ONLY: If on birth control pills, it is important to understand that antibiotics have been reported to decrease the effectiveness of oral contraceptives resulting in the chance of unplanned pregnancy. If antibiotics are prescribed, other contraceptive methods are recommended to avoid pregnancy.

All of my questions have been answered to my satisfaction and I consent to the treatment/procedures prescribed for me/the patient.

I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS FORM, OR IT WAS READ TO ME, AND THAT ALL BLANKS WERE FILLED IN AND ALL INAPPLICABLE PARAGRAPHS, IF ANY, WERE CROSSED OUT BEFORE I SIGNED BELOW

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SIGNATURE OF PERSON CONSENTING TO TREATMENT DATE

KURT E. DELIUS, .D.D.S., M.S.
Periodontics and
Dental Implants

10123 Lake Creek Parkway Bldg 1
Austin, Texas 78729
(512) 335-3600

REQUEST AND CONSENT FOR PERIODONTAL SURGERY

I request and authorize Dr. Kurt E. Delius, and whomever he designates as his assistants to perform the following treatment/procedure(s) for:

Name of Patient: _____

Description of Patient's Condition/Problem Being Treated: _____

_____

Description of Treatment/Procedure(s): _____

_____

I understand that periodontal surgery is intended to correct anatomical deficiencies, arrest further progression of the disease process and generally to maintain a tooth/teeth that may otherwise be lost. I have had explained to me, and I have had sufficient opportunity to discuss my/the patient's dental condition, the treatment procedure(s), and the benefits to be reasonably expected from this treatment. I further authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by Dr. Kurt E. Delius to diagnose and/or treat my/the dental condition(s).

ALTERNATIVES: The alternatives to the proposed treatment/procedure(s) have been discussed with me to include but not limited to initial non surgical therapy alone or maintenance therapy only. I also understand that if no treatment is rendered, the periodontal condition may worsen, disease may progress and teeth may be lost.

RISKS: The usual and most frequent risks and complications related to the planned treatment/procedure have been explained to me. These risks include but are not limited to: the possibility of pain or discomfort during and following treatment, gum recession, thermal sensitivity, bruising, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporary or permanent numbness, allergic reactions. During treatment, unforeseen complications may be discovered which proper surgical procedure dictates should be treated at that time. I therefore consent to the performance of such additional or alternative procedures as may be indicated by proper surgical care. This may include but is not limited to extraction of the tooth/teeth If necessary.

NO WARRANTY: I have been informed that the long term success of treatment requires my cooperation including daily oral hygiene to control plaque as well as regular periodic recall visits upon completion of the proposed treatment/procedure. I understand that there is always the risk of treatment failure, relapse, or worsening of the periodontal condition despite treatment. I acknowledge that no guarantees have been given to me regarding the results of treatment, or whether it will be curative and/or successful to my complete satisfaction.

I have been advised that medications prescribed may cause drowsiness and lack of awareness and coordination. Because of this, I understand that it is not advisable to operate any vehicle, automobile, or hazardous device until fully recovered from their effects.

WOMEN ONLY: If on birth control pills, it is important to understand that antibiotics have been reported to decrease the effectiveness of oral contraceptives resulting in the chance of unplanned pregnancy. If antibiotics are prescribed, other contraceptive methods are recommended to avoid pregnancy.

All of my questions have been answered to my satisfaction and I consent to the treatment/procedures prescribed for me/the patient.

I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS FORM, OR IT WAS READ TO ME, AND THAT ALL BLANKS WERE FILLED IN AND ALL INAPPLICABLE PARAGRAPHS, IF ANY, WERE CROSSED OUT BEFORE I SIGNED BELOW

_____ _____

SIGNATURE OF PERSON CONSENTING TO TREATMENT DATE

Kurt E. Delius, D.D.S., M.S.

Periodontics and Dental Implants

REQUEST AND CONSENT FOR SEDATION

I request and authorize Dr. Kurt E. Delius and whomever he designates as his assistants to use local anesthetics and sedative drugs in performing dental treatment for:

Name of Patient: _____

Any exceptions, please note: _____

_____

I understand that the anesthetics/sedative drugs are necessary to assist in the performance of the dental treatment with increased patient comfort and cooperation.

RISKS: I have been informed and I understand that there are associated risks with the use of local anesthetic agents and sedative drugs used to increase patient comfort and to control patient behavior. The risks that occur occasionally include, but are not limited to: numbness; inflammation of the veins used for administration of the drugs; bruising or discoloration of the tissue surrounding the injection site; swelling infection; bleeding; nausea; vomiting; and allergic reactions.

I have been informed and I understand that in rare instances, the risks of sedative drugs include but are not limited to: breathing difficulties; brain damage; stroke; heart attack; or loss of function of any body limb or body organ. I understand that severe complications may require hospitalization and may even result in death.

The purpose and possible complications to the use of sedative drugs have been explained to me as well as possible alternative methods and there advantages and disadvantages. I understand the purpose, possible risks, and probable effectiveness of each method or approach to treatment as well as the probable result if no treatment is provided.

I have been advised that good results are expected and that the possibility and exact nature of complications cannot be accurately predicted. I acknowledge that no expressed or implied guarantees as to the result of treatment or the use of anesthetic or sedative drugs have been given to me.

I acknowledge that I have received written pre-operative and post-operative instructions regarding the sedation procedure and the use of sedative drugs, that these instructions have been explained to me, and that I understand this information.

I have had the opportunity to ask all of my questions and all of my questions have been answered to my satisfaction and I consent to the treatment/procedures prescribed for me/the patient. I believe that I have been given adequate information upon which to base an informed consent.

I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS FORM, OR IT WAS READ TO ME, AND THAT ALL BLANKS WERE FILLED IN AND ALL INAPPLICABLE PARAGRAPHS, IF ANY, WERE CROSSED OUT BEFORE I SIGNED BELOW

_____ _____

SIGNATURE OF PERSON CONSENTING TO TREATMENT DATE

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Austin, TX 78729 (512)335-3600