INFORMED CONSENT FOR ENDOSSEOUS IMPLANT

GEORGIA STATE LAW REQUIRES THAT WE OBTAIN YOUR CONSENT PRIOR TO THIS SURGICAL PROCEDURE

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

REQUEST AND INFORMED CONSENT
DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Patient’s Name:
Date:

The following has been explained to me in general terms and I understand that:

(1) The diagnosis requiring this procedure is: Loss of a tooth or teeth inadequate prosthetic support.
(2) The nature of the procedure is surgical placement of an endosseous implant.
(3) The purpose of the procedure is to gain additional prosthetic support.
(4) The likelihood of success of the above procedure is:
   ( ) Good    ( ) fair    ( ) poor
(5) Practical alternatives to this procedure; not doing an implant, removable denture or preparing adjacent teeth and fabricating a fixed bridge.

PATIENT’S INITIALS:_________
(6) If I choose not to have the above procedure, my prognosis (future medical condition) is: additional bone loss, inadequate occlusal support, and changes in existing teeth.

(7) Material risks of this procedure:

Procedure will be done with Nitrous/Oxide sedation and local anesthetic. If procedure was being performed under general anesthesia: (I.V. sedation) there may be material risks of: INFECTION, LOSS OF FUNCTION OR OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:

(a) Injury to the nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue: this may persist for several weeks, months or in permanently.

(b) Post-operative discomfort and swelling that may necessitate several days of home recuperation.

(c) Injury to adjacent teeth and fillings.

(d) Stretching of the corners of the mouth with resultant cracking and bruising.

(e) Restricted mouth opening for several days or weeks.

(f) Breakage of the jaw.

(g) The implant may not heal properly and 2nd surgical procedure may be required to remove the implant. Fitting the bone requiring a 2nd impression procedure

(h) Postoperative infections may occur requiring additional treatment.

I understand that the medical-dental personnel and others will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure, which, has been explained.

I understand that the practice of dentistry and medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

PATIENT'S INITIALS: ___________
I understand that during the course of the procedure described, it may
be necessary or appropriate to perform additional procedures, which
are unforeseen or not, known to be needed at the time this consent is
given. I consent to and authorize the persons described herein to make
the decisions concerning such procedures. I also consent to and
authorized the performance of such additional procedures, as they
deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia. X-ray
examinations, and other treatment or courses of treatment relating to
the diagnosis or procedures described herein.

I also consent that any tissues or specimens removed from the
patient's body in the course of any procedures may be tested for
scientific purposes and then disposed of within the discretion of the
physician, facility, or other health care provider.

I understand that certain medications, drugs, anesthetics, and pre-
scriptions may cause drowsiness and lack of awareness and
coordination, which may be increased by the use of alcohol or other
drugs, thus I have been advised not to operate any vehicle,
automobiles, hazardous device. Or work while taking medications and
or drugs: or until fully recovered from the effects. I understand and
agree that if I have been sedated or given general anesthesia, I will
not operate any vehicle or hazardous device for 24 hours after my
release from surgery or until further recovered from the effects of the
intravenous anesthesia, and drugs that may have been given to me in
the office or hospital for my care. If intravenous anesthesia is used, I
agree not to drive myself home after surgery and will have a
responsible adult drive me home after being discharged from surgery.

Female patient's: Research indicates that the reliability of oral
contraceptives can be significantly diminished with the use of some
antibiotics and other medications which may be used during the
course of treatment. According to the advice of your OB-GYN, alternative or
additional forms of birth control should be used until the course of
antibiotics or prescribed medication is completed.

PATIENT'S INITIALS:___________
I understand that this (request for) and consent to surgical or diagnostic services shall be valid for the responsible for the dentist surgeon, all medical-dental personnel under direct supervision and control of the responsible oral and maxillofacial surgeon and for all other medical dental personnel otherwise involved in the course of treatment.

I understand that smoking, alcohol and sugar intake may adversely effect healing and increase the likelihood of postoperative infections, which may limit the success and prognosis of the surgery and future treatment performed. I agree not to smoke for 2 weeks prior to surgery and not to smoke following surgery.

I consent to photographs, recordings, and x-rays of the procedure to be performed for the advancement of dentistry.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND IT’S CONSENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ALL QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGN THIS FORM I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN. I HAVE HAD THE OPPORTUNITY TO EVALUATE THE CREDENTIALS AND EDUCATIONAL BACKGROUND OF THE TREATING DOCTORS.
I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Dayo Obebe, involved un the course of my treatment.

Person giving the consent (patient or legal guardian)

Relationship to patient if not the patient:

Patient is unable to sign because of:

Witness

Doctor