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Diplomate of the American Board of Periodontology
Practice Limited to Periodontics and Dental Implants

PATIENT INFORMATION AND CONSENT FORM FOR IMPLANT SURGERY

Patient's Name:_____

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. Dr. Lacrampe 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 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 or altered sensation 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 medications used.

4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are TMJ (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and sore muscles when chewing.

5. Dr. Lacrampe has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of the implant.

6. I have been informed and understand that the final esthetic result of the dental restoration may be compromised due to several factors including bone and/or soft tissue anatomy. I have been advised that additional treatments may be required to improve the esthetic result and that in some cases ideal esthetics may not be possible.

7. It has been explained that in some instances the 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 treatment or surgery can be made.

8. I understand that smoking may affect gum healing and may limit the success of the implant. I agree to follow Dr. Lacrampe's home care instructions. I agree to report to Dr. Lacrampe for regular examinations as instructed.

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, anaesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.

10. 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 in my best interest.

Date:_____ Patient's Signature:_____

Date:_____ Dr. Lacrampe's Signature:_____