Waterman
Oral and Maxillofacial Surgery

Tyler E Nelson, DMD, MD
John R Saunderson, DMD
(707) 428-5427 Fax: (707) 428-1922
watermanomfs@gmail.com
2801 Waterman Blvd. Ste. #240
Fairfield, CA 94534

Implant Consent Form

____ 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.

____ My doctor 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 replace the missing teeth.

____ 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 reaction to drugs or medications used, etc.

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

____ It has been explained to me 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 assurance as to the outcome of results of treatment or surgery can be made.

____ I understand that smoking, alcohol or sugar 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.

____ I agree to the type of anesthesia, depending on the choice of the doctor. 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.

____ 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, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

____ I consent to photography, filming, recording and x-rays of the procedure for the advancement of implant dentistry, provided my identity is not revealed.

____ 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.

Date:_____ Time:_____:_____ am / pm

Patient: _____

Doctor: _____ Witness: _____