

## IMPLANT INFORMATION AND CONSENT FORM FOR

- \_\_\_\_1. I have discussed with Dr. Provines concerning the type of implant system that will be used; namely **Keystone Dental/Lifecore Biomedical**.
- \_\_\_\_2. Reasonable alternatives to implants have been explained to me. I have tried or considered these methods, but I desire an implant(s) to help secure the replaced missing teeth.
- \_\_\_\_3. I have further been informed of all possible risks and complications associated with the surgical procedures. These complications include, but are not limited to, full or partial, temporary or permanent numbness of the lip, tongue, cheek, chin, gum tissue, or teeth, injury to adjacent teeth, jaw fractures, sinus penetration, infections, pain, sensitivity, delayed healing of the surgical site and bruising of facial tissue. **If you are taking a type of drug called a bisphosphonate, you may be at risk for developing osteonecrosis of the jaw and certain dental treatments may increase that risk.**
- \_\_\_\_4. I understand that if no treatment is rendered at this time, any of the following may occur: further loss of bone (making it impossible to place implants in the future), continued irritation and inflammation of the gum tissue, sensitivity, loosening or infection of teeth, followed by the necessity for extractions or improper chewing function due to missing natural teeth.
- \_\_\_\_5. I understand that smoking, alcohol or increased sugar consumption may negatively affect tissue healing and could alter the prognosis of the implants after placement.
- \_\_\_\_6. I have been informed and understand that implant surgery is a complex and intricate procedure and the results are unpredictable. There were no guarantees or assurances made as to the outcome of treatment or surgery. The doctor has explained that failures do and have occurred.
- \_\_\_\_7. The type of anesthesia, which I have agreed to use, will be **Local Anesthetic**. I will not operate a motor vehicle or hazardous device until I have fully recovered from the effects of the anesthesia given.
- \_\_\_\_9. I request and authorize the services that will be necessary for the placement of osseointegrated implants and understand that conditions may change which will require additional or alternative treatments. I approve any modification of design or treatments if, in the doctor's judgement, it becomes necessary and is in my best interest.

\_\_\_\_\_  
Signature of **Joe A. Provines, D.M.D.**

\_\_\_\_\_  
Signature of **Patient**

\_\_\_\_\_  
WITNESS (Optional)

\_\_\_\_\_  
Date

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