Perio & Implants

Consent for the Removal of Dental Implants

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

Diagnosis, Implant Removal:
After a careful oral examination, Dr's Abron, Jose, or Miller has advised to me that my implant {s} needs to be removed.

Recommended Treatment:
In order to treat my condition, Dr's Abron, Jose or Miller has recommended the removal of my dental implant (s). I understand that the procedure involves removing the implant (s) from the jaw bone or sinuses. I understand that a local anesthetic will be administered to me as part of the treatment and sedation may be utilized.

Surgical Phase:
My gum tissue will be reflected to expose the bone. Implants will be removed from my jawbone. There is a potential risk of jaw bone fracture with this type of procedure. The soft tissue will be stitched closed over or around the surgical area. Healing will be allowed to proceed for a period of 4 to 6 months or possibly more.

I understand that during surgery, clinical conditions turn out to be unfavorable for the replacements of implants. Dr's Abron, Jose or Miller will make a professional judgment on the management of the situation. The procedure may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw lo facilitate the replacement of the implants.

Alternatives to Suggested Treatment:
I understand that alternatives to this procedure include: no treatment. However continued wearing of ill-fitting appliances and or not treating recurring infections can result in further damage to the bone and soft tissue of the mouth.

Primary Risks and Complications:
I understand that a small number of patients do not respond successfully to surgery, and in such cases, the involved teeth may eventually be lost. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the surgery, drugs, and anesthetics. These complications include, but are not limited to:

- Bleeding, swelling and pain
- Allergic reactions
- Post-surgical infections
- Impact on speech

- Facial discoloration (bruise)
- Accidental swallowing of foreign objects
- Transient or permanent numbness of the lip, tongue, teeth, chin or gum
- Transient or permanent tooth sensitivity to hot, cold, sweet or acidic foods
- Delayed healing
- Jaw joint injuries or muscle spasms
- Cracking or bruising of the corners of the mouth; breakout of cold sores
- Restricted ability to open mouth for several days or weeks
- Worsening of the condition
- Transient or permanent tooth looseness
- Fracture of adjacent restorations or teeth
- Exposure of crown margins on teeth with crowns/bridges/veneers

I understand that if I smoke, I have more risk for the above complications. The exact duration of any complication(s) cannot be determined, and they may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

To my knowledge, I have reported to my surgeon any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which may in any way relate to this surgical procedure.

No Warranty or Guarantee:
I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a therapist cannot predict certainty of success. There exists the risk of failure, relapse. Additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants. Despite the best care.

Patient Consent:
I have been fully informed of the nature of the required extraction or oral surgery, the risks and benefits, the alternative treatments available, and the necessity for follow-up care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my surgeon. After thorough deliberation, I hereby consent to the performance of extraction or oral surgery as presented to me during consultation and in the treatment plan presented to me. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my surgeon. I understand that these additional or alternative procedures may involve added cost that may not have been outlined in the estimate of treatment costs.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

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Patient's Signature	Patient's Name
Signature of Doctor	Date
Signature of Witness	Date

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