I UNDERSTAND that dental treatment requiring ORAL SURGERY and/or IMPLANT PLACEMENT and/or RETAINED CROWN-BRIDGE-DENTURE PROSTHETICS ON DENTAL IMPLANTS, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) Dental implants can and do fail, either shortly after placement, or years later. Implant failure may happen due to the body rejecting the implant, periodontal disease due to inadequate oral hygiene, and other reasons that cannot be predicted under any circumstance, no matter how precise and carefully the surgery of the placement of implants and implant devices was performed. If rejection of the implant occurs, removal will most likely be necessary.

_____(initials) Determining the lifespan of dental implants and their respective restorative prosthetics cannot ever be predicted, due to so many variables that are not in the dentist's control.

_____(initials) I understand no matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or a general feeling of being uncomfortable, I will contact the dentist/dental office to seek further treatment. In some cases, hospitalization and/or treatment with I.V. antibiotics may become necessary, and I also assume those risks.

_____(initials) I understand injury to nerves in the lips, tongue, cheeks and other tissue in the mouth can possibly happen. These potential nerve injuries can cause numbness, tingling, burning or loss of taste. These potential nerve injuries may be temporary, lasting a few days, weeks, or months, and in rare cases can be permanent.

_____(initials) Bleeding, bruising, and swelling may happen during and after the procedure(s). Bruising may be prolonged after surgery. Slight bleeding may last several hours. Should bleeding persist, you must contact our office immediately, especially if you feel light-headed while standing.

_____(initials) Habits such as smoking and drinking will reduce the healing phase of implant surgery. Smoking alone can cause complete implant failure. It is imperative that you do not smoke for at least six weeks after surgery, and even that may not be sufficient enough to improve integration of the dental implant to the bone tissue. It is absolutely imperative that you tell your doctor if you have these habits prior to implant placement.

_____(initials) It is recommended that patients who receive dental implant placement have their implants cleaned more often than twice a year. The dentist and dental hygienist will advise you on what will be best for your situation.

_____(initials) It is not always possible for dental implants to be placed in the most ideal locations due to bone thickness, bone densities, and other anatomical limitations you may have. Your dental implant will be placed in the most favorable location for integration. However, there may be compromises to esthetics and function to complete the procedure. Biting forces on such placement compromises may result in implant failure years after placement. The doctor does not, nor can be expected to, have total control over some implant placements into your jaw bones.

_____(initials) Injury to adjacent teeth, fillings or porcelain crowns may occur no matter how carefully surgical procedures are performed. Fractured fillings or crowns may require replacement.

_____(initials) Unusual reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to the doctor's instructions. If you are a female on oral contraceptives, you must be aware that antibiotics can render those contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during treatment.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warranties have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

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