Preston Hollow Periodontics & Implantology, PC
Jeffrey Pope, DDS, MS

PATIENT CONSENT FOR IMPLANT SURGERY

I have been informed of 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 in the bone.

Dr. Pope has carefully examined my mouth. Alternatives to this treatment have been explained. I have considered other alternatives, but I desire an implant(s) to help secure the replaced missing tooth/teeth.

I have been further informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include, but are not limited to, pain, swelling, infection, joint strain, vertigo, etc. 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 injury to teeth, bone fractures, sinus perforation, delayed healing, allergic reactions to drugs or medications used, etc.

I understand that if nothing is done, any of the following may occur: loss of bone, loss of gum tissue, looseness of teeth, etc. Also possible are tempromandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles when chewing.

Dr. Pope 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 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 other systemic diseases (i.e. diabetes, etc.) may affect gum and bone healing and may limit the success of the implant. I agree to follow Dr. Pope's home care instructions. I agree to report to Dr. Pope for regular examinations as instructed.

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 Dr. Pope, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if Dr. Pope feels this is in my best interest.

I certify that I have read and fully understand the above authorization and informed consent to implant treatment and the explanations referred to above.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ DATE: _____

WITNESS: _____ DATE: _____