



It has been explained that, while implants normally have an extremely high long term success rate, in some instances, implants fail and must be removed. I have been informed and I understand that, due to the nature of the treatment, and the number of factors involved in the success of said treatment, no guarantees or assurances can be made for the outcome of treatment or surgery. Further I understand that the success of the implants will determine the design of the final restorations being placed and whether it will be permanently fixed or removable.\_\_\_\_\_

I recognize that extensive use of smoking, alcohol, recreational drugs, or sugar may affect healing and may limit the success of the implant. I agree to follow my doctor's home care instructions and agree to report to my doctor for regular examinations as instructed.\_\_\_\_\_

I understand that my implants, like my teeth require regular exams and cleanings, in order to prevent gum disease and bone loss, and that if I do not come for regular care of my implants and teeth that gingivitis and peri-implantitis may lead to the eventual loss of my implant.\_\_\_\_\_

I understand that failing implants would require surgical removal and may require additional prosthodontics procedures or the subsequent placement of additional implants.\_\_\_\_\_

I agree to the type of anaesthesia, depending on the choice of the doctor. I understand that I must not operate a motor vehicle or hazardous device for at least 24 hours or more until I have recovered from the effects of the anaesthesia or drugs administered from my care.\_\_\_\_\_

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

I request and authorize that medical/dental services, such as implants and other surgery may be done for me. I fully understand that during and following the intended procedure, surgery, or treatment, conditions may become apparent which will demand the judgement of the doctor and additional or alternative action needed, such as **BONE GRAFTING** procedures to ensure the success of comprehensive treatment. I also approved of any changes in design, materials, or care, if it is felt needed for my best interest.\_\_\_\_\_

I have had ample opportunity to read this form and ask any questions, and had my questions answered satisfactorily.\_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature