ADC™
CENTRE FOR RESTORATIVE AND IMPLANT DENTISTRY

CONSENT FORM FOR DENTAL IMPLANT

Patient Name: Date of Birth:

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. I request and authorize _____(ADC- Centre for Restorative and Implant Dentistry) or his/her associates or assistants to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

   Dental implants are Metal (TITANIUM and alloys) anchors put inside the jawbone underneath the gumline. Small posts are attached to the implants, and artificial teeth or dentures are fastened to the posts.

   Most patients need two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. The second procedure will uncover the implants to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of fixed or removable bridgework or a denture, are fastened to the posts. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also may be necessary to install the anchors and posts which may require additional Surgical Procedures and extra costs and expenses for which I am liable to pay.

   The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures.
2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications.
3. I consent to the administration of anesthesia or other medications before OR during the procedure by qualified personnel the cost which shall be born by me. I understand that all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs both known and unknown causes.
4. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following:
   - Postoperative discomfort and swelling
   - Bleeding
   - Postoperative infection

- Injury or damage to adjacent teeth or roots of the teeth
- Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums or tongue
- Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints of the jaw — temporomandibular joint (TMJ) syndrome
- Fracture of the jaw
- Bone loss of the jaw
- Penetration into the sinus cavity
- Mechanical failure of the anchor, posts or attached teeth
- Failure of the implant itself
- Allergic or adverse reaction to any medications

Most of these risks, complications and side effects are not serious or do not happen frequently. But although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization, or blood transfusions. Very rarely, the potential risks and complications could result in permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment or procedures as required. You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

5. It has been explained that in some instances implant(s) fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; therefore, I understand there are no guarantees or assurances as to the outcome of treatment results.
6. Follow-up care for the implants and prosthesis is extremely important to the success. It will be necessary to return to the Dental office in Sector 21 Chandigarh, India at regular intervals for examination and service. It has been made clear that failure on my part to keep my mouth, implant post(s) and prosthesis thoroughly clean may jeopardize the success of my implant(s). I realize that unforeseen long-term factors may necessitate additional surgery, modification of the implant(s) or even surgical removal of the implant(s). I also understand that I will be financially responsible for long term maintenance and/or any modifications required, including but not limited to cleanings, attachment replacements, x-rays, and examinations.
7. To my knowledge, I have given an accurate report of my physical and mental health history. I understand that excessive smoking, alcohol, or blood sugar may effect gum healing and may limit the success of the implant(s) and restoration. I will report any significant change in my health should it occur.

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8. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
9. I agree to notify the doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (two to four weeks), so future follow-up care may be established.
10. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different that now contemplated. I further authorize and direct my doctor, associate or assistant to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant restoration.
11. I certify that I have read or had been read to me the contents of this form in my language and signing the consent form under no pressure or influence whatsoever and will follow any and all patient instructions related to this procedure. I am aware that the payment is required on the day of treatment and I wish to receive promotional, appointment and other intimations from ADC- Centre for Restorative and Implant Dentistry. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient Date

Signature of the Doctor Date

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CENTRE FOR RESTORATIVE AND IMPLANT DENTISTRY

CONSENT FORM FOR DENTAL IMPLANT RESTORATIONS

Patient Name: Date of Birth:

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

I request and authorize _____(ADC- Centre for Restorative and Implant Dentistry) or his/her associates or assistants to perform the Restorations of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

1. The purpose of dental implant(s) is to provide stability, support and/or retention for a crown, fixed bridge or fixed denture in the absence of natural teeth. Based upon thorough examination and discussion, I request the fabrication of implant prosthesis. I approve any future modification in prosthetic design; materials or treatment if, in the doctor's professional judgment, he feels that it is in my best interest.
   - Fixed- Similar to natural teeth in color and size
   - Fixed- Longer and/or larger than natural teeth, and of similar color
   - Fixed- Longer and/or larger than teeth, with tooth color and pink to replace missing gum
2. I have been informed and afforded the time to fully understand the purpose and the nature of the implant restorative procedure. I understand what is necessary to accomplish the restoration of the implant previously inserted into or onto the bone and under the gum.
3. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant prosthesis to help secure the replacement of my missing teeth. The entire procedure has been fully explained, including the benefits and possible risks. I have been given the opportunity to ask questions regarding the procedure and they have been answered to my satisfaction. I have not asked for, nor have I received from anyone, a guarantee of the outcome of this procedure.
4. The possible risks and complications for fixed prostheses include: compromised appearance and/or lack of support of the lip(s) and cheek(s) as a result of inadequate bone; air escaping underneath the prosthesis while talking which may affect speech and/or food entrapment underneath the prosthesis since space is necessary for homecare of implant. The possible risks for prostheses include: sore gums, food entrapment, wearing of attachments, replacement of attachment components, and initial problems with speech.
5. Excessive forces, as grinding or clenching my teeth, on the implant(s) may lead to loosening and/or fracture of the retaining screws or cement; fracture of the porcelain, metal or acrylic on the prosthesis; loosening and/or fracture of the implant(s); and/or loss of bone around the implant(s). Any of these may cause loss of this implant(s). Additional treatment and associated costs will be involved should this occur, including, but no limited to occlusal guards.

6. I understand that if nothing is done any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint, jaw problems, headaches, referred pains to the back of the neck and facial muscles and fatigued muscles when chewing. In addition, I am aware that if nothing is done at the present time, future bone loss may cause the inability to place implant(s) at a later date due to changes in oral or medical condition(s).
7. It has been explained that in some instances implant(s) fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; therefore, I understand there are no guarantees or assurances as to the outcome of treatment results.
8. Follow-up care for the implants and prosthesis is extremely important to the success. It will be necessary to return to the Dental office in Sector 21 Chandigarh, India at regular intervals for examination and service. It has been made clear that failure on my part to keep my mouth, implant post(s) and prosthesis thoroughly clean may jeopardize the success of my implant(s). I realize that unforeseen long-term factors may necessitate additional surgery, modification of the implant(s) or even surgical removal of the implant(s). I also understand that I will be financially responsible for long term maintenance and/or any modifications required, including but not limited to cleanings, attachment replacements, x-rays, and examinations.
9. To my knowledge, I have given an accurate report of my physical and mental health history. I understand that excessive smoking, alcohol, or blood sugar may effect gum healing and may limit the success of the implant(s) and restoration. I will report any significant change in my health should it occur.
10. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
11. I agree to notify the doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (two to four weeks), so future follow-up care may be established.
12. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different that now contemplated. I further authorize and direct my doctor, associate or assistant to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant restoration.
13. I certify that I have read or had been read to me the contents of this form in my language and signing the consent form under no pressure or influence whatsoever and will follow any and all patient instructions related to this procedure. I am aware that the payment is required on the day of treatment and I wish to receive promotional, appointment and other intimations from ADC- Centre for Restorative and Implant Dentistry. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient Date

Signature of the Doctor Date