Jamila
MILLER D.D.S., M.S.D.
Prosthodontics & General Dentistry
9333 Calumet Ave., Suite D • Munster, IN 46321 • (219)836-4214 • drjamilamiller.com

Please read consent form. Signatures will be required at the office the day of your procedure.

PROSTHODONTIC INFORMED CONSENT FOR IMPLANT TREATMENT

I have been informed during my consultation about the nature of my proposed implant treatment including the nature of implants, implant surgery, risks of treatment, prosthodontic treatment and about alternatives to this treatment including no treatment.

1. **IMPLANT SUCCESS.** I understand that for implants to be successful they normally must bond directly to the jawbone (called Osseointegration). It has been explained to me that implants are not 100% successful and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implant(s) or will be removable by me.

2. TREATMENT. I understand that the initial surgical procedure involves making an incision in the gums and exposing the underlying jawbone. Holes are then drilled into the bone and the implant(s) are placed into these holes. The gums are then stitched closed, and the area allowed to heal for variable period of time (3-6 months or more). I understand that I will have to avoid wearing my denture(s) for 1-2 weeks until healing is complete. After the healing period a second surgical procedure is performed to expose the implant(s) and attach extensions onto them which will eventually support the restoration(s). After this second surgery the prosthodontic phase of my treatment will take place, which will involve several appointments.

3. ALTERNATIVE TO IMPLANTS. I have considered the following alternatives to implant treatment:

1. No treatment
2. Construction of conventional complete or partial denture(s).
3. Tooth replacement with conventional bridgework supported by my remaining natural teeth (if possible).

4. RISKS OF IMPLANT TREATMENT. I have been informed and I understand that the risks of no treatment include, but are not limited to the following:

1. Continuing use of removable partial or complete denture with associated potential for discomfort and shirking of the jawbones which would require periodic relining or remaking of the denture(s).
2. Periodontal disease (gum disease or pyorrha) which could lead to the loss of teeth if not treated.
3. Tooth decay which could lead to the loss of teeth if not treated.
4. Shifting and drifting of the remaining teeth, changes to the bite.

5. RISKS OF IMPLANT TREATMENT. I understand that surgical risks include, but are not limited to the following:

1. Infection
2. Bleeding
3. Adverse drug reactions
4. Discomfort
5. Bruising

6. Perforation of the sinus or floor of the nose
7. Nerve damage
8. Bone fracture
9. Jaw joint injury
10. Loss of one or more implants
11. Nerve damage may be transient or permanent and can result in numbness, tingling, or other sensations n the lower lip.

I understand that prosthodontic risks include, but are not limited to the following:

1. Failure of an implant to fuse to the bone (osseointegrate)
2. Fracture of the restoration and/or implant components
3. Wear of the restoration requiring remake
4. Compromised esthetic or functional outcome because of implant loss than ideal angulations or position of the implant(s)

I understand that failing implant(s) would require surgical removal and may require additional prosthodontic procedures or the subsequent placement of additional implant(s).

6. NO GUARANTEE. No guarantee or warranty of any kind has been made to me that the proposed implant treatment will be 100% successful or that the final restoration(s) will be totally successful from a functional or esthetic (appearance) standpoint. I understand that no medical or dental procedure is totally predictable and that this includes treatment with dental implants. I understand that because of unknown or unforeseen factors, further surgical or prosthodontic procedures beyond those described to me might be necessary. I also understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene procedures as directed by the doctor and that I return for scheduled follow-up and recall appointments.

I have had an opportunity to read this form, ask questions, and have my questions answered to my satisfaction. I hereby consent to the placement of implant(s) in my mouth and the associated prosthodontic procedures for restoring the implant(s).

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