

*Miranda & Ortega D.M.D. P.A.*

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## **Implant Patient Information & Consent Form**

1. I have been informed 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 under the gum or in the bone.
2. Dr. Miranda has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but desire implants to help secure the replaced missing teeth.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include but are not limited to pain, swelling, infection, nerve injury, sinus floor penetration, bone fracture, delayed wound healing, allergic reactions to drugs or medications used and damage to adjacent teeth or structures. Numbness of the lip, tongue, chin, cheek, or teeth may occur and the exact duration may not be determinable and may be irreversible.
4. I understand that if nothing is done to replace the missing tooth I will continue to have jaw bone loss in that area and around adjacent teeth. This may result in sensitivity, mobility, or drifting, weakening or breakdown and eventual loss of adjacent teeth. This may possibly lead to temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and inefficient chewing or unstable occlusion (bite).
5. Dr. Miranda has explained that there is no method to accurately predict how the bone and gum will heal after placement of dental implant(s) and that he will follow up with me as necessary to assure the best possible outcome.
6. It has been explained that in some instances dental implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science and can vary from one individual to another; thus no guarantees or assurance as to the outcome or results of treatment or surgery can be made.
7. I understand that smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant(s). I agree to follow my doctor's home care instructions given. I agree to report to my doctor for regular examinations as instructed.
8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs prescribed for my care.

9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health.
10. I consent to photography and x-rays as needed for documentation and follow up purposes to be performed during and after the procedure, provided my identity is not revealed.
11. 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 judgement of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

SIGNATURE OF DOCTOR \_\_\_\_\_

SIGNATURE OF PATIENT \_\_\_\_\_

(If the patient is unable to sign, then signature of parent or legal guardian)

WITNESS \_\_\_\_\_

DATE \_\_\_\_\_