DAVID B. KRILL, D.M.D., INC.
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PERIODONTICS AND ORAL DIAGNOSIS
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An explanation of your need for dental implants, the procedure and post-operative care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo this procedure. Please read this document which repeats issues we discussed and provide the appropriate signatures on the last page. Please ask us to clarify anything that you do not understand.

PATIENT'S CONSENT FOR DENTAL IMPLANTS

PURPOSE OF IMPLANTS: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

ALTERNATIVE TREATMENT: Reasonable alternatives to implants have been explained to me. I have tried or considered these methods, but I desire an implant to help secure replacement for missing teeth.

TYPE OF IMPLANT: I am aware that the type of implant(s) to be used on me is one which is placed into the jawbone; that this is done by first reflecting a flap of gum, preparing a site in the bone, then inserting the implant into the bone and finally covering the bone and implant with the gum flap.

SURGICAL PROCEDURES: I understand that multiple surgeries are necessary: one to insert the implant(s) as described above, and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed.

RISKS: Risks related to the surgery include but are not limited to post surgical infection, bleeding, swelling, pain, facial discoloration, upper jaw sinus or nasal cavity perforation during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth or chin, jaw joint injuries or associated muscle spasm, bone fractures and slow healing. Prosthetic risks include but are not limited to unsuccessful union of the implants(s) to the jaw bone and stress metal fracture of the implant(s). If any of these occur, a separate surgical procedure would be necessary to remove the failed implant(s). Risks related to the anesthetics include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, inflammation, soreness, discoloration or blockage along a vein at the injection site.

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NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated (hoped) that the implant(s) will be permanently retained, but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long term success cannot be guaranteed.

CONSENT TO UNFORSEEN CONDITIONS: During treatment, unknown conditions may modify or change the original treatment plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I therefore consent to the performance of such additional or alternative procedures as may be required by proper care in the best judgment of the treating doctor.

DRUG EFFECTS AFTER SURGERY: I have been informed that prescribed medications may cause drowsiness, alone or in combination with alcohol and/or other sedatives, and I agree not to drive or operate dangerous machinery within 12 hours of taking any such medication or if drowsiness occurs. Furthermore, if sedative medications are to be administered during surgery, I will not attempt to drive myself home after the surgery, but will arrange to be driven and accompanied home.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the success of the implant(s). I agree to follow instructions related to my own daily care of my mouth. I agree to report to my doctor for regular follow-up examinations as instructed.

RESPONSIBILITY FOR PROSTHETIC SUCCESS: I understand that the fabrication and attachment of prosthetic devices (attachments and tooth replacements) will be the responsibility of another dentist and that the long-term maintenance, repair, and success of these devices will be the sole responsibility of the dentist who provides this prosthetic care.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed or any other reasonable alternative treatment, that such a decision is my sole responsibility. I acknowledge that risks related to my non-acceptance of treatment for my problem have been explained to me and include but are not limited to dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bones, further gum recession, problems with my bite including pain, spasm, headaches or problems with my jaw joints or associated musculature.

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SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and reading this document, I have been encouraged to seek another opinion form a dentist knowledgeable in the area of implant(s). It has also been suggested that I discuss this entire procedure with another person in whom I have confidence, such as my spouse, a relative or close friend, prior to completing my deliberation and decision.

PATIENT'S SIGNATURE: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to the placement of dental implant(s) as presented to me during consultation and treatment plan presentation by the doctor.

Patient's Signature (Signature of Parent or Legal Guardian if the Patient Is a minor)	Date	Relationship of Patient
		Patient's Name
Signature of Doctor	Date	
Signature of Witness	Date	