Halfmoon Family Dental

CONSENT FOR IMPLANT SURGERY

I _______________________________ hereby authorize Dr. Swalsky to perform implant surgery. I have been informed that the purpose of the surgery is to place a dental implant(s) into the supporting jawbone.

If any unforeseen condition should arise in the course of the surgery calling for Dr. Swalsky's judgment for additional procedures different from those now treatment planned, I authorize the Doctor to do whatever he may deem advisable.

Post-operative risks of the proposed surgery include, but are not limited to;

- pain
- restricted mouth opening for several days, weeks or longer
- parasthesia (numbness) of the jaw or gum nerves which may persist for several weeks, months or in remote instances, permanently
- gum recession (shrinkage)
- temporary or, in rare instances, permanent interference with phonetics (speech sounds)
- clicking or pain of the temporomandibular joints (jaw joints)
- tooth sensitivity to hot or cold for days, weeks or, on occasion, several months
- transient or in some instances, permanent tooth mobility (looseness) in selected areas
- food lodging between the teeth after meals, requiring cleaning devices such as floss for removal
- unaesthetic exposure of crown margins of teeth in the surgery area

Further, I have been informed of other possible alternatives and/or supplemental methods of treatment, if any. I further understand that if no treatment is rendered, my present condition will probably worsen in time.

No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment or worsening of my present condition despite the best of care. However, it is Dr. Swalsky's opinion that therapy will be helpful and that any further loss of supporting tissues or bone would occur sooner without recommended treatment.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic dental cleaning visits (recall professional care).

I consent to photographs of my oral and facial structures and their publications for educational and scientific purposes.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT, THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

________________________________ ________________________________
Dentist Signature Patient Signature

________________________________ ________________________________
Parent/Guardian Signature if Patient is a Minor Witness

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Date