COPPER CANYON DENTISTRY
MARK A. POITRAS, DDS
*Patient-centered dentistry, where your comfort comes first*

## Discussion and Informed Consent for Implant Placement

**Facts for Consideration/Patient's initials required**

_____ Dental implants are used to replace missing teeth and provide a base for artificial teeth. Implant placement and restoration involves two major stages: surgical placement of the implant(s) followed by the restoration of the implant after osseointegration (the process in which the bone grows around the implant) has occurred.

_____ Dental implants are titanium (metal) anchors placed into the jawbone, underneath the gum tissue, to support artificial teeth where natural teeth are missing. When the bone attaches itself to the implant, these implants act as tooth root substitutes and form a strong foundation to stabilize the customized, artificial teeth.

_____ I understand that the placement of implants and the making of compatible prostheses are two separate treatments with separate expenses and separate risks and benefits.

_____ I understand that in order for the implants to be placed in my bone my gum tissue will be opened to expose the bone. Implants are placed by pushing or threading them into holes in the bone. The implants will have to be snugly fitted and held tightly in place during the healing phase.

_____ I understand that the soft tissue will be sutured closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of three to nine months.

_____ I understand that for those types of implants that require a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be tested. If the implant appears satisfactory, an attachment (abutment) will be attached to the implant. The restorative phase to create a prosthetic appliance or crown(s) can begin.

_____ I understand that no specific estimate can be made regarding the period for the longevity and retention of the implant. If fixtures have to be removed, I should be able to return to using a conventional denture or partial denture or possibly have additional fixtures placed in the future. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant(s) may fail.

_____ I understand that additional maintenance and repair may be expected for the implants. I am responsible for all surgical costs after the first year of treatment or surgery. I agree to follow pre- and post-operative instructions.

_____ I understand that dentures or removable prostheses usually cannot be worn during the first one to two weeks of the healing phase.

_____ I understand that the practice of dentistry is not an exact science; no guarantees or assurances can be made regarding the outcome or the results of treatment or surgery.

_____ Short-term effects after surgery: There may be normal side effects that Dr. will instruct me how to handle at home, such as swelling, stiffness of the jaw muscles, bruising, occasional oozing of blood for 24 to 48 hours or moderate pain for 24 to 48 hours.

**Use of Local Anesthesia**

_____ Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection.

_____ Risks include but are not limited to: It is normal for the numbness to take time to wear off after treatment, usually four to six hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur.

_____ Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during the dental treatment.

_____ For ALL female patients: Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the provider if she could be or is pregnant. Anesthetics, medications and drugs may affect the behavior of a nursing baby. In either of these situations, the anesthesia and treatment may be postponed.

**Risks of Implant Placement**:

_____ Risks, not limited to the following: Though dental implant surgery has a high rate of success, like all surgery it carries with it the possibility of complications not limited to the following:

~ swelling that worsens after 48 hours;
~ intense pain that cannot be relieved by prescription medication;
~ infection;
~ permanent loss or alteration of nerve sensation resulting in numbess or tingling sensation in the lip, tongue (including loss of taste), cheek, chin, gums, or teeth;
~ sinus complications;
~ excessive or prolonged bleeding;
~ TMJ (temporomandibular jaw joint) pain or abnormal function of the jaw, jaw fracture;
~ adjacent teeth, roots, fillings or bridgework injuries or damage;
~ bone loss around implant; and
~ implant failure and loss (the bone does not grow around the implant).

_____ I understand if any of the above occurs I must immediately contact Dr. Mark Poitras.

**Benefits, not limited to the following**: Increased chewing efficiency and improved appearance or speech are the most common benefits.

_____ Consequences of implants and prostheses in the mouth: I understand that smoking, excessive alcohol consumption, chewing hard foods such as ice or hard candy, may result in damage to my implants and can cause them to fail completely. Although implants can have a very high success rate, there is a higher rate of failure associated with those that smoke.

_____ I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking and any medical conditions I am have. I attest that my medical history is up to date and accurate so that may dentist may ensure my safety during the procedure.

_____ I understand that I must keep my implants and prostheses clean by daily maintenance as well as regular checkups and cleanings at my dentist office.

**Alternative Treatment Plans to Implant Placement:**

Option 1: No Replacement of Missing Teeth

_____ Risks, not limited to the following: Compromised aesthetics and possible drift of adjacent and/or opposing teeth into the spaces(s) with the resultant collapse of the arch integrity. I understand that if no treatment is elected an inability to place implants at a later date due to changes in oral or medical conditions could occur.

_____ Benefits, not limited to the following: No additional costs at this time.

_____ Consequences if no treatment is administered, not limited to the following: I understand that I can choose to do nothing and my present complaints will continue and may worsen. Subsequent choices for repairs may become more difficult, expensive, or not feasible.

Options 2 & 3: Removable or Fixed Appliances

_____ Removable or fixed appliances without implants have been explained to me by Dr. Mark Poitras as an alternative to implant supported restorations. The risks, benefits, and consequences of the two types of appliances were also explained to me, including stress on other teeth, gums, or bone, fit, retention and appearance.

Patient Criteria
Almost anybody who is missing teeth can benefit from implant treatment. Those who are experiencing chewing problems and difficulty wearing a removable appliance can look to a restoration anchored to an implant as a possible treatment plan. Those who do not have a disease or condition that interferes with proper healing after implant surgery, i.e., uncontrolled diabetes or radiation/chemotherapy for treating cancer, and who have sufficient bone that is dense enough to secure the implants are possible candidates for an implant treatment plan.

_____ I understand the importance informing Dr. Mark Poitras of any known medications, allergies, or prior reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to health.

_____ I understand that Dr. Mark Poitras may decide to cancel the implant surgery once it is underway if I need supplemental bone grafts or other types of grafts to build up the ridge to allow placement, gum closure, and securing of the implant(s). It may even be discovered once the surgery is underway that I am not a candidate for implant treatment.

_____ I request and authorize dental services for myself, including implant surgery and other related treatment. I fully understand that during the contemplated surgery, or treatment; conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in design, materials, or care, if my doctor determines this in for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated or if clinical conditions turn out to be unfavorable for the use of implant(s) or prevent the placement of implants, I further understand, authorize and direct my doctor, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the treatment.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the conditions listed above.

**Initial only one of the spaces below that applies to you:**

_____ I have had my questions answered to my satisfaction. I consent to have Dr. Mark Poitras perform the treatment as discussed. I authorize and direct this dentist, with his associates, to do whatever they deem necessary and advisable under the circumstances.

Or

_____ I refuse to give my consent for the proposed treatments(s) as described above and understand the potential for consequences associated with this refusal.

_____ _____
Patients Signature (or Patient's Representative) Date

_____ _____
Patients Signature (or Patient's Representative) Date

_____ _____
Patients Signature (or Patient's Representative) Date

_____ _____
Patients Signature (or Patient's Representative) Date