Seitlin & Seitlin DDS
Informed Consent for Implant Restorations

Patient Name: Date of Birth:

I. Recommended Treatment

I hereby give consent to Dr. Seitlin to restore my dental implant/s on me or my dependent as follows (to be known as "Recommended Treatment"):

- ❑ Single crown on implant in the position of tooth #
- ❑ Fixed bridge on implants in the position of teeth #
- ❑ Implant-retained removable partial denture(s) replacing teeth #
- ❑ Implant-retained removable full denture(s) replacing teeth #
- Other

I give consent for this Recommended Treatment and any such additional procedure(s) as may be considered necessary for my well-being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Alternatives to Implant Restorations

- Replacement of the missing tooth or teeth by a tooth-supported fixed bridge. Natural teeth next to the toothless space are used to support a bridge, which is cemented into place and is non-removable. This procedure requires drilling the natural teeth to properly shape them to support the fixed bridge.
- Replacement of the missing tooth or teeth by a removable partial denture or full denture. Partial and full dentures are removed from the mouth for cleaning. They are supported by the remaining teeth and bone and retained by the remaining teeth, cheeks, lips, and tongue.
- No treatment is an option. I may decide not to replace the missing tooth or teeth. If I decide upon no treatment, my teeth may shift over time, causing chewing or gum problems.

III. Risks

I have been informed and fully understand that there are certain inherent and potential risks associated with implant restorations.

- I may experience pain or discomfort during and/or after treatment.
- I understand that an implant restoration may not relieve my symptoms or meet my expectations for comfort, function, or esthetics.
- I understand that I may notice slight changes in my bite.
- I understand that during and for several days following treatment, I may experience stiff or sore jaws from keeping my mouth open.
- I understand that it is possible for an infection or other problems to occur in or around an implant site and/or the surrounding gums, and that I may need antibiotics and/or other procedures, such as periodontal (gum) surgery around the implant, to treat the infection.
- I understand this may occur during or after treatment. I understand that my gums may recede after the completion of my implant restoration. This condition may also require periodontal (gum) surgery.
- I understand that poor eating habits, poor oral habits (clenching, grinding, smoking, tobacco chewing, fingernail biting, etc.), poor oral hygiene, and certain medical conditions, such as diabetes, will negatively affect how long my implant restoration lasts.
- I understand that spaces may open up over a period of years around my implant crown and it may need to be replaced to close these spaces.
- I understand that I may be given a local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.
- Other unforeseeable risks not stated above

By signing, I acknowledge I have been informed about the recommended treatment, alternatives, and risks, and I wish to proceed.

Signature:

Date:

Relationship (if patient a minor): Witness (signature):