

# Discussion and Informed Consent for Implant-Supported Restoration(s)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_

## Nature of Implant Restoration

Implant-supported restorations can replace missing teeth. They differ from conventional restorations in that they are supported by dental implants rather than by natural teeth. The use of dental implants permits missing teeth to be replaced with crowns, fixed bridges and/or dentures that are supported or retained by their attachment to the implant(s).

### It has been recommended that I have the following implant-supported restoration(s):

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: \_\_\_\_\_

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken and on my doctor's knowledge of my medical and dental history. My treatment needs and desires have also been taken into consideration. The prognosis or likelihood of success of this procedure is

\_\_\_\_\_  
\_\_\_\_\_

However, I understand that no guarantee, warranty or assurance has been given to me that this treatment will be successful or last for any length of time.

### Patient's initials required:

\_\_\_\_\_ I understand that after surgical placement of the implant(s) is/are completed and healed, the construction of the prosthesis and/or crowns begins. This may require multiple appointments for evaluation, measurement, gum preparation and placement.

### Risks, including but not limited to the following:

\_\_\_\_\_ I understand fixed prosthesis are customized restorations or replacements of missing teeth that are cemented to the implant(s). I understand the potential problems with fixed prostheses, including implants, are the same as with my real teeth, such as periodontal (gum) disease, porcelain fractures, occlusal changes, color changes, food impaction, excessive wear due to teeth grinding and bruxing or temporomandibular joint (TMJ) dysfunction (TMJD) and others.

\_\_\_\_\_ I understand the new prosthesis may be either *removable* by the dentist but not by the patient or it may be *removable* by the patient. In either circumstance, the prosthesis will have similar risks, benefits and consequences as the removable prosthesis described above (which I have discussed with my dentist). In the instance of being anchored to an implant integrated in my bone, this type of removable prosthetic appliance will function more like my natural teeth.

\_\_\_\_\_ I understand that my implant(s) may not fully integrate (fuse to the bone) following surgery even though they appear to be integrated after healing is completed. I understand if an individual implant must be removed, the prosthesis may be retained but *will be supported by fewer implants* and thus place a greater load on the remaining implants, which may have *adverse consequences*. The success of the prosthesis depends upon many factors, including the location, angle and number of retained implants.

\_\_\_\_\_ I understand that sometimes implants fail completely and must be removed, requiring a change in treatment considerations and a fabrication of a conventional prosthesis instead. If that should happen, there may be less bone than there was before the implant surgery.

\_\_\_\_\_ I understand that when osseointegration (bone grows around the implant) is successful, the implant supports a firmly anchored prosthesis with sufficient function; however, the desired appearance may be difficult to achieve. I have discussed this and am willing to work with my dentist to achieve a realistic outcome.

\_\_\_\_\_ I understand that following implant surgery and the placement of the prosthesis, there may be inflammation of the gum tissue around the posts and some excess tissue growth or recession. Some situations may require surgical alteration or refinement of the tissue.

\_\_\_\_\_ I understand that there may be progressive loss of the bone height around the implant over the life of the implant that may ultimately affect the prosthesis.

*b. Benefits, including but not limited to the following:*

\_\_\_\_\_ I understand that a reasonable aesthetic appearance of my edentulous (toothless) areas can be reached and my ability to chew can be improved.

*c. Consequences, including but not limited to the following:*

\_\_\_\_\_ I understand that it is essential to maintain excellent oral hygiene, which may not be easy to achieve. I am committed to a lifetime of regular home cleaning and periodic professional dental hygiene visits. There will be space for cleaning around the implants, but it may be difficult for me until I learn the skill.

\_\_\_\_\_ I understand that smoking, excessive alcohol consumption and chewing hard foods such as ice or hard candy may result in damage to my implants and cause them to fail and be lost. I understand that a medical condition can compromise the long-term outcome of an implant.

\_\_\_\_\_ I understand that there may be a feeling of awkwardness with the new prosthesis. The post(s) may seem to be in places where I find them difficult to accommodate and my speech may be labored until I am accustomed to the new prosthesis.

**Alternatives to Implant Restoration:**

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to implant-supported tooth replacement. I understand that possible alternatives to an implant-supported prosthesis may be:

**Replacement of the missing tooth or teeth by a tooth-supported fixed bridge.** Natural teeth next to the missing tooth space are used to support a bridge, which is cemented into place and is nonremovable. 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. Dentures do not stop the loss of bone and may require more attention later.

**No treatment.** 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.

\_\_\_\_\_ I understand that the placement of implants and the making of the compatible prosthetic devices are two separate treatments with separate expenses. I understand that in addition to the risks and complications associated with implants and prosthetics certain complications may result from the use of anesthetics or sedatives. The risks, benefits and alternatives regarding anesthesia will be explained to me and I will disclose any allergies I have because they may affect my response to the anesthetic.

**Check the boxes below that apply to you:**

**Consent**

- I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.
- I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.
- I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. \_\_\_\_\_ to do whatever he/she deems necessary and advisable under the circumstances.
- I consent to have the above mentioned treatment.
- While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

**or**

**Refusal**

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

\_\_\_\_\_

Patient or Patient's Representative

\_\_\_\_\_

Date

\_\_\_\_\_

Witness Signature

\_\_\_\_\_

Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with \_\_\_\_\_ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

\_\_\_\_\_

Dentist Signature

\_\_\_\_\_

Date