MOUNTAIN TOP
periodontics & implants

8000 E. Prentice Ave. Unit D7
Greenwood Village, CO 80111
(303) 740-0080

IMPLANT INFORMED CONSENT

I have been informed and I understand the purpose and nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum and in to the bone.

The doctor has carefully examined my dentition. Alternatives to this treatment have been explained. I have tried or considered these alternative methods, but I desire an implant to replace missing teeth.

I understand that an abutment and a crown, denture or bridge will later be attached to the implant by my restorative dentist and that the cost of the restorative phase is not included in the fee for this procedure.

I acknowledge that if I am a smoker, any medical or dental surgical procedure carries an element of risk for complications and/or failure. Risk factors can vary greatly from patient to patient. Smoking has been documented to delay wound healing and therefore increases the risks of having complications and/or failure. I acknowledge that being a smoker may increase my risk of failure and post-operative complications, including but not limited to, pain, swelling and infection. No labor warranty applies to implant procedures performed on patients who have smoked within two months prior to treatment.

I understand that no guarantee has been given. Though an implant should last for many years, I understand the importance of regular dental examinations and personal oral hygiene being followed and completed on schedule.

I have been informed that the implant will remain covered under the gum tissue for an adequate amount of time to enable healing and that a second surgical procedure will be needed to uncover the top of the implant enabling restoration.

In the unlikely event of failure of the implant there is no refund of the fee. I understand that any fees related to replacement of a failed implant after restoration are my sole responsibility.

To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, anesthetics, pollens, dust, blood, or body disease, gum or skin reactions, abnormal bleeding and/or any other conditions related to my health.

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I authorize and direct the specialist to provide such additional services as he/she deems reasonable and necessary, including, but not limited to administration of anesthetic agents, laboratory, radiological and other diagnostic procedures and administration of oral medications.

In the interest of the advancement of implant dentistry, provided that my identity is not revealed, I consent to photography, filming, recording and x-rays of the procedure.

I have read the above information and fully understand what will take place during surgery and acknowledge that my questions have been answered. By signing below I give my permission for the surgery and am in agreement to signing this consent.

Patient Name: _____

Signature: _____

Date: _____