Patient Name:_____ Implant Site Number:_____

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An explanation of your need for dental implants, their purpose and benefits, surgeries related to their placement and subsequent exposure, possible complications as well as implant alternatives were discussed with you at your consultation, which we obtained your verbal consent to undergo the treatment planned for you. Please read this document which repeats issues we discussed in its entirety and provide the appropriate signature on the last page. Please ask us to clarify anything that you do not understand and answer any of your questions at any time.

Patient's Consent for dental implants

PURPOSE OF IMPLANTS: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

ALTERNATIVE TREATMENT: Reasonable alternatives to implants have been explained to me. I have tried or considered these alternative methods, but desire implant(s) to help secure a missing tooth or teeth being replaced.

TYPE OF IMPLANT: I am aware that the type of implant selected is one which is surgically placed into the jawbone. Implant surgery is accomplished by the dentist first reflecting a flap of gum tissue, preparing a reception site in the bone, next inserting the implant into the bone and finally covering the bone and implant with the previously opened or reflected gum flap.

SURGICAL PROCEDURES: I understand that multiple surgeries may be necessary: first one to insert the implant(s) as described above, another to uncover the top of the implant(s) so that it is exposed for attachment of a tooth, bridge, or denture. I also understand that sometimes it is beneficial to add bone or gum tissue grafts at the implant site either prior to implant placement or after the implant has healed. I also understand that sometimes the implant is covered with a bone graft barrier to further enhance healing which may necessitate an additional procedure(s) and expense.

RISKS: General risks related to the surgery include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, muscle spasm, bone fractures, slow healing or unsuccessful union of the implant(s) to the jawbone. The final crown, bridge, or bar denture can occasionally cause stress metal fracture(s) of the implant(s) necessitating replacement or removal.
Specific risks include but are not limited to:

_____Upper jaw-sinus or nasal cavity perforation during the surgery or a result as a complication.
_____Lower jaw-temporary but on occasion permanent numbness of the lip, tongue, teeth or chin.
If failure of an implant(s) occurs, a separate surgical procedure may be necessary to remove the failed implant(s) and consider replacement.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed implant(s) will be permanently retained but because of the uniqueness of every patient's personal wound healing dynamic any long- or short-term success cannot be promised.
Patient Name:_____ Implant Site Number:_____

CONSENT TO UNFORESEEN CONDITIONS: During treatment, unknown considerations may modify or change the original treatment plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for
the implant(s). I therefore consent to the performance of such additional or alternative procedures as many be required by proper dental care in the judgement of the treating dentist.

DRUG EFFECTS AFTER SURGERY: I have been informed that prescribed medications may cause drowsiness alone or in combination with alcohol and/or other sedatives. Therefore, I agree to not drive or operate dangerous machinery with 12 hours of taking any such medication or if drowsiness occurs at any time. Furthermore, if sedative medications are to be administered during surgery, I will not attempt to drive myself home after the surgery but will instead arrange to be driven and accompanied home by a responsible person.

COMPLIANCE WITH SELF CARE INSTRUCTIONS: I understand that smoking or alcohol intake may affect gum healing and impair adversely affect implant(s) success. Carbonated beverages may also adversely affect healing and implant success. I agree to follow instructions during the healing phase after implant(s) are placed and for daily maintenance of my implant(s) and mouth after healing has occurred. I agree to return visits to my doctor for regular follow-up examinations as instructed.

RESPONSIBILITY FOR PROSTHETIC SUCCESS: I understand that the making and attachment of the tooth replacements constructed of the implant(s) is separate additional treatment. Long-term maintenance, repair and success of these devices is the responsibility of the dentist who provides the tooth replacement constructed over the implants(s). Care and cleaning of the appliances are the patient's responsibility.

SUPPLEMENTAL RECORDS AND THEIR USE: I understand that if I elect no treatment as proposed (or any other
suggested reasonable alternative treatment) that after such refusal to treat it is my sole responsibility and may potentially reduce available bone for future implants if I delay implant surgery now, but later elect (chose) implant surgery. Risks related to my non-acceptance of implant surgery which have been explained to me include but are not limited to:

dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bone (bone-loss), additional gum recession, bite problems, jaw, muscle or joint pain, or headaches.

SECOND OPINION: If any significant doubt or questionable understand persists after receiving explanations and reading this document, I have been encouraged to seek another opinion from another dentist knowledgeable in the area of implants. I also may wish to discuss this entire procedure with other interested parties such as my spouse, a relative, or close friend, prior to making my decision, who may attend with me at another consultation to answer any questions.

PATIENT'S ENDORSEMENT: My endorsement (signature) to the form indicates that I have read and fully understand the terms and words within this document and the explanations referred and that the after careful consideration, consent to the performance of any and all procedures related to other surgical placement of dental implants as present to me during consultation and treatment plan presentation by the doctor and as described in this document. Any question I have regarding proposed implant surgery were answered by the doctor.

_____/_____
Patient's Signature (Signature of Parent or Legal Guardian) Date

_____/_____
Signature of Doctor Date

_____/_____
Signature of Witness (relation to patient?) Date