INFORMED CONSENT FOR DENTAL IMPLANT TREATMENT

After careful oral examination, the treating dentist at Advanced Dental Services of Jacksonville has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by implant(s). I hereby give consent to Dr. Andrew Maples and/or Dr. Brian Maples to complete this recommended treatment.

The procedure I have chosen to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials of human, animal, or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage, and retention for these teeth.

I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a bridge, a partial denture, full denture, or other options. If I don't have the procedure completed, my condition may stay the same, improve, or get worse. It is the doctor's opinion that the proposed procedure is a better option for me. I understand and choose to undergo the placement of implant(s).

The treating dentist has fully explained to me the purpose of the operation/procedure and has also informed me of the expected benefits and complications (from known and unknown causes) associated with the recommended treatment. The discomforts and risks that may arise have been thoroughly explained. The risks discussed include, but are not limited to the following:

- Restricted mouth opening.
- Gum shrinkage.
- Temporomandibular joint trauma. Stiffness or limited jaw opening.
- Tooth sensitivity to hot or cold.
- Loose teeth.
- Food lodging between the teeth requiring flossing for removal.
- Unesthetic exposure of crown margins of teeth in the surgery area.
- Injury of adjacent teeth and/or fillings.
- Interference with speech sounds.
- Permanent nerve injury possibly requiring nerve graft surgery.
- Damage to anatomical structures (i.e. blood vessels, nerves, glands, etc.).
- Infection.
- Bleeding.
- An opening to the sinus or sinus infection.
- Severe pain or inflammatory swelling (edema).
- Small, loose bony spicules (sequestrum) or bony irregularities.
- Porcelain fracture of the final crown or bridge restoring the implant(s).
- Implant failure necessitating removal.
- Smoking decreases bone graft success rates by 50% and implant success rates by 15%.

I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional procedures which the above-named dentist may consider necessary.

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, need for more treatment, or worsening of my present condition despite careful treatment.

The benefits, risks, and complications associated with local anesthesia and sedation have been thoroughly reviewed with me. The risks discussed include, but are not limited to: partial or complete paralysis of facial nerve(s), hematoma (a swelling that contains blood), fracturing of the anesthetic needle, temporary or permanent numbness, allergic reaction, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac conditions, decreased heart rate, and depressed breathing. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

I consent to photography, filming, and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
I confirm that I have read and fully understand the above and I agree to cooperate completely with the doctor's recommendations while receiving care at Advanced Dental Services of Jacksonville.

PRINTED NAME	SIGNATURE	DATE