

## Informed Consent for Implant Removal

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

**Purpose of Implant Removal:** I have been informed that the purpose of removing my implant(s) is

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**Alternative Treatment:** The following reasonable alternatives to removing the implant(s) have been explained to me:

- Retaining implant(s) as is.

**Surgical Procedure may involve some, or all, of the following:**

- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics, and sutures (stitches).
- Use of a bone graft to preserve the bone on neighboring teeth or to provide sufficient bone volume for a future implant. The bone may be my own bone, human donor bone or cow bone. A membrane may also be utilized, which may require an additional procedure to remove the membrane.

**Risks and Complications of Implant Removal Surgery:** I understand that the risks and complications include, but are not limited to:

- Allergic reactions to dental, materials/ medications,
- Bleeding, swelling, infection,
- Pain and/or tooth sensitivity,
- Perforation of the upper jaw, sinus, or nasal,
- Cavity,
- Bruising,
- Bone fracture,
- Scarring,
- Damage to other teeth/roots - which may need repair or removal,
- Damage to other dental appliances,
- Cracking/stretching corners of the mouth,
- Cuts inside mouth or on lips,
- Slow healing,
- Temporary restriction of mouth opening,
- Stress or damage to jaw points (TMJ),
- Increased tooth/teeth mobility of neighboring teeth,
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate, chin) including loss of taste which may resolve over time, but in some cases may be permanent,
- Dry socket,
- Bony ridges or splinters that may require further treatment,
- Nerve injury in the place the graft was taken from or where it is placed.
- Rare chance of disease spread from processed bone,
- Failure/infection of the bone graft.

**Risks and Complications of local anesthetic use:** I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: nerve injury, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions usually resolve, but in some cases may be permanent.

**Consent to Unforeseen Conditions:** During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

**Compliance with Self-Care Instructions:**

In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand the necessity of maintaining good oral hygiene for better healing and that tobacco and alcohol products may negatively affect healing.

**Supplemental Records and Their Use:** I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

**Patient's Endorsement:** My endorsement (signature to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to the completion of the implant removal and bone grafting as presented to me during the consultation and treatment plan presentation by the dentist.

You or your responsible party will have the opportunity to sign an electronic copy of this form when you arrive at our office for your appointment.