

CNA Sample Form: Discussion and Consent for Implant Placement Surgery

Patient's Name _____ Date of Birth _____
Last First Initial

I am being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning, I wish to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that **I may ask any questions I wish**, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Implant Placement Surgery

Dental implants are titanium metal screws surgically placed in the jaw as a substitute for natural tooth roots. Implants permit missing teeth to be replaced through the use of crowns, fixed bridges, or dentures, which attach to the top(s) of the implant(s). It has been recommended that I have a total of _____ dental implant fixtures placed in the following tooth positions or areas of my mouth: _____.

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 needs and desires have also been taken into consideration.

Implant placement surgery involves opening the gums and creating a hole in the jawbone for each dental implant. The dental implant is placed snugly in the custom hole created for it. The gums are then stitched closed over the implant. Follow-up visits are required. Following placement, implants require time to heal and attach to the surrounding bone before replacement teeth can be made to fasten on top of them. I understand my expected healing time will be _____ months. During this time, I may be without replacement teeth. A second surgery is then necessary to uncover the implant and prepare it for use.

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 for how long.

My implant(s) is (are) estimated to cost \$_____ and estimated to take _____ visit(s) to complete. After implant placement, it is estimated that I will be able to proceed replacing my missing teeth in _____ months.

Alternatives to Implant Placement Surgery

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to implant placement and 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 toothless space are used to support a bridge, which is cemented into place and is non-removable. 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.
- **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 have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.
Patient's Initials

Risks of Implant Placement Surgery

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including surgical implant placement. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, and/or bruising, all of which may last for several days. I understand that it is possible for an infection to occur in or around the implant site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure and sinus infection (upper arch); limited ability to fully open your mouth; soreness in the jaw joints (TMJs).

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Patient's Name: _____

I understand that the implant(s) may fail to properly integrate to the surrounding bone and may require removal. I understand that this may occur for unknown reasons. I understand that the use of tobacco products (smoking or chewing), and certain medical conditions, such as diabetes, increase the risk that the implant(s) will fail and will require removal. I understand that poor eating habits and poor oral hygiene may negatively affect how long my implants last. I understand that the design and construction of my replacement tooth or teeth may contribute to implant failure.

I understand that following implant placement surgery, I may have nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues. I understand this risk is greater in the lower jaw.

I understand that additional surgical procedures may be necessary based on findings and observations revealed during surgery that are not now known.

I understand that I will be given a local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

Other foreseeable risks not stated above include: _____.

_____ Patient's
Initials I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including: _____.

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the recommended treatment.

_____ Patient's
Initials I understand this treatment can also be performed by a oral surgeon or a periodontist (dental specialists). I understand the risks and elect to have this procedure performed by Dr. _____.

I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon or periodontist for further surgical care.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

This sample form is for illustrative purposes only. Your implant placement procedures and risks may be different than those described. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.