**INFORMED CONSENT -- IMPLANT SURGERY**

What you are being asked to sign is a confirmation that we have discussed:

The nature and the purpose of the treatment.

The known risks associated with the treatment.

The feasible treatment alternatives.

It also confirms that you have been given an opportunity to ask questions and that all your questions have been answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand.

The practice of dentistry is not an exact science and reputable practitioners cannot guarantee results. Please understand that no one can promise that any treatment or dental procedure will be successful, or that any risk, complication or injury will not occur. No promise or warranty has been made to you by Dr. Burgoyne, or by any of his staff or assistants, as to the result of the treatment, or as to any risk, complication or injury that may arise from the treatment, anaesthetic or diagnostic procedures.

**My signature at the end of this form certifies that:**

1. 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 the bone. I also understand that upon entering the surgical site it may be determined that implant placement is not possible.
2. Dr. Burgoyne/Wong has carefully examined my mouth and explained the alternatives to this treatment. I have tried or considered these methods, but desire an implant to help secure the replaced missing teeth.
3. I have been informed of the possible risks and complications involved with surgery, drugs and anaesthesia. These complications include pain, swelling, infection, bruising, numbness of the lip, tongue, chin, cheek or teeth. The exact duration may not be determinable and may be irreversible. Also possible are: inflammation of a vein, injuries to teeth present, bone fractures, sinus penetration, delayed healing, and allergic reactions to drugs or used medications.

**4**. I understand that if I do not pursue implant therapy any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth and loss of teeth. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

**5**. Dr. Burgoyne/Wong has explained that there is no method to accurately predict the gum and the bone healing capabilities of each patient following the placement of an implant.

**6**. It was explained that an implant might not integrate or become infected after placement or restoration and must be removed. I have been informed and understand that the practice of dentistry is not an exact science and that guarantees or assurances as to the outcome or the results of treatment cannot be made.

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**INFORMED CONSENT -- IMPLANT SURGERY (cont’d)**

**My signature at the end of this form certifies that:**

**7.** All information I have supplied is complete and accurate with regard to present and past medical history. This also applies to all medications I am presently taking and to any and all knowledge concerning allergies or toxic reactions of any kind to any medication. I understand that medical changes in my health and less than adequate oral hygiene, or inconsistent periodic examinations, may limit the longevity of the prosthesis.

**8**. I understand that excessive smoking, alcohol or sugar may affect gum healing and may limit the success of the implant. I agree to follow Dr. Burgoyne and Wong’s home care instructions. I agree to report to Dr. Burgoyne/Wong for regular examinations as instructed.

**9**. I agree to return for examination as frequently as Dr. Burgoyne/Wong requests, and understand that his office will monitor my progress, unless he advises me to return to my general dentist for this care.

**10**. I consent to the taking of necessary radiographs for the pre-treatment diagnosis and follow-up care.

**11**. I consent to being referred to competent practitioners for a second opinion and possible treatment, if that should become necessary.

**12.** I understand and agree to my responsibility for payment for services rendered. I also understand that the written estimate for treatment is as accurate as possible at the outset of treatment, but due to physiologic differences between each patient, it can only be considered an estimate.

**13.** I request and authorize dental services for me. I fully understand that during the following contemplated treatment, conditions may become apparent that warrant, in the judgment of Dr. Burgoyne/Wong, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification of design, materials or care, if Dr. Burgoyne/Wong decides that this is in my best interest.

**Smoking and Dental Implants**

There is overwhelming scientific evidence that smoking will adversely affect the healing of tissues after dental implant surgery. There is also strong evidence that there is a higher rate of implant failure, both short and long term in smokers. If you smoke and choose to continue to smoke before and after implant surgery, we will not be responsible for the financial consequences of implant failure, either immediate or long term.

I hereby state that I have read and that I understand this consent, that Dr. Burgoyne/Wong has given me an opportunity to ask any questions I might have had, and that those questions have been answered in a satisfactory manner. I also understand that I am free to withdraw my consent to treatment at any time.

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Patient or guardian Witness

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Dentist

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Date