SCHNEIDER
DENTAL
DESIGNS

3633 W Lake St
Glenview, Illinois, 60025
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DENTAL IMPLANT CONSENT FORM

Upon thorough diagnosis, Dr Schneider has determined that a dental implant is indicated. I, the undersigned, understand that an implant is an elective procedure, and that Dr Schneider has explained to me the process of the implant placement and the anticipated results. I fully understand the potential risks associated therewith, which are listed below:

a) Possible damage to adjacent teeth or other structures, especially those teeth with large fillings or crown.
b) Prolonged numbness due to the proximity of the implant to nerve structures.
c) Limited jaw opening due to inflammation or swelling.
d) Medications, drugs, anesthetics, or other chemicals utilized for this procedure may cause drowsiness and lack of awareness and coordination, or other unanticipated reactions that may require medical treatment.
e) Failure of the implant to take (osseointegrate) resulting in having to remove and replace the original implant.
f) Change in the restorative plan due to the position of the implant, healing of the implant, and whether or not all of the implants take.
g) Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or a referral to an Oral Surgeon for further treatment.

I acknowledge that the cost quoted to me includes the placement of the implant(s) in the bone and the anesthesia only. The cost of the abutment fixtures and the final restoration are additional expenses. These additional costs should be discussed with Dr Schneider.

I acknowledge that during treatment, conditions may develop which may require further surgery. Such procedures include, but are not limited to, mucosal/gingival grafting, treatment of infection of the soft tissue or bone, and surgical treatment of the sinus infection. I realize there may be additional cost for these procedures.

In some instances, following an implant, a bone graft may be recommended around the placed implant. Bone grafts help prevent resorption of the bone around the implant placement. Dr Schneider will discuss this on a case-by-case basis.

I am aware that I may have continuing temporary symptoms throughout and after implant placement, which may include:

a) Post-operative swelling, pain, or bleeding;
b) Swelling of the corners of the mouth, potentially resulting in cracking and bruising;
c) Post-operative infection, potentially requiring antibiotics;
d) Post-operative drainage;
e) Fever;
f) Numbness.

By signing below, I have reviewed the above with Dr Schneider and have asked any questions that I may have. I, the undersigned, being the patient (or the parent or guardian of the minor named) understand the foregoing, and consent to the performance of the procedure.

Patient Name____________________________ Patient (Parent/Guardian) Signature________________________

Date___________Doctor Name_____________________________ Doctor Signature________________________

Date___________ Implant Type_____________________________ Bone Graft (Yes/No)_____________________