Informed Consent for Surgical Implant Placement

Patient's name ______________________________________ Date of Birth___________________

I am being provided 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 and confident 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 the Recommended Treatment

It has been recommended that I have the following treatment:

- ☐ Surgical placement of dental implants at:____
- ☐ Repair bony defect with addition of bone from the following sources
  - Freeze-dried cadaver bone (human bone)
  - Demineralized Bovine Bone (cow bone)
  - Synthetic Bone
- ☐ Sinus Lift (surgical change the shape of the floor of your sinus cavity for better placement of dental implant
- ☐ Other:____

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. The treatment is necessary because of my need to restore the missing teeth area in the follow location(s):____

Prognosis:

I understand that no dental treatment is complete risk free and that ***Dr. Jin and his staff*** will take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include: pain, swelling, prolong bleeding, difficulty to chew, difficult to swallow food, excessive sinus pressure, extended numbness to my lips, jaw and tongue, and other surgically related complications.

Alternate Treatments:

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative methods to treat my dental conditions include:___________________________
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I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of the procedure.

Patient Signature: X___________________________________ Date:_______________

Witness Signature: X__________________________________ Date:_______________