PERIO HEALTH PARTNERS
Periodontal & Dental Implant Surgical Center

PERIODONTAL/IMPLANT INFORMATION AND CONSENT FORM

1. I have been informed of the possible risks and complications involved with scaling and root planing, prophylaxis, surgery, drugs, and anesthesia. Such complications include pain, root sensitivity, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur, as well as loss of facial muscle tone and/or loss of bone and cheek contour. The exact duration is variable and may be irreversible. Also, possible are inflammation of tissues, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, necrosis of bone due to bisphosphonates and previous radiation therapy.

2. If I am to have an implant(s), I have been informed and I understand the purpose and the nature of the implant surgery procedure, which is to replace missing teeth. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

3. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained which include fixed or removable partial dentures, full dentures, or no treatment. If I will be having implants, I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

4. Patients recommended for osseous bone graft; an osseous graft is used in situations where the doctor believes that a bone graft will promote osteogenic (bone) healing and may improve treatment outcome for my periodontal disease or implant(s). If the bone graft is not performed, the chances of periodontal regeneration and implant success are greatly reduced.

5. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness, and movement of teeth, followed by necessity of extraction. Also, possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

6. It has been explained that in some instances, implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment or surgery can be made.

7. I understand that smoking, alcohol, or eating prohibited foods may effect gum healing and may limit the success of the surgery and implant(s). I agree to follow my doctor's home care instructions and also comply with proper post surgical follow-up as necessary to monitor healing. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the type of anesthesia, depending on the choice of the doctor, following proper explanation. If given a sedative, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care. I understand that I must not drive to and from the surgical appointment if sedation is given.

9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health. I have listed all medications taken including over the counter medications, vitamins and herbals. I will keep my doctor updated on any changes to my health.

10. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Initial this consent form (page 1), attachment for consent form (page 2) and sign knowledge of consent (page 3) ⇨

Initials: _____

Date: _____

1815 S. Clinton Ave, Suite #500, Rochester, NY 14618
Phone: 585-376-5300 Fax: 585-376-5302 *www.periohealthpartners.com*

Patient Name: _____

Procedure: _____

_____

KNOWLEDGE OF
PERIODONTAL/IMPLANT INFORMATION AND CONSENT FORM
AND ATTACHMENT FOR PERIODONTAL/IMPLANT INFORMATION AND CONSENT FORM

_____ a. I am aware and accept that, in addition to the risks described on the previous page (as the practice of dentistry is not an exact science), there may be other risks not usually encountered or expected that may occur. I also acknowledge that no guarantees have been made to me about the results of the proposed treatment.

_____ b. I authorize the administration of local anesthetics, nitrous oxide in combination with oxygen, sedatives, hypnotics and/or analgesics as indicated, to aid and assist in completing the treatment of surgical procedures described in above. I also authorize the disposal of any tissues or teeth removed or the preservation of such tissue or teeth, for scientific purposes.

_____ c. I understand that photographs may be taken of me or my child, for educational or treatment related purposes. All photographs used for presentation or educational purposes are anonymous.

_____ d. I have had an opportunity to discuss my child's dental problem(s) and the proposed treatment plan(s) with the treating dentist and all questions have been answered to my satisfaction. Therefore, I believe I have adequate knowledge upon which to grant an informed consent to the proposed treatment.

_____ e. I have received a copy of information on grafting products that may or may not be used during the procedure.

_____ f. I impose no specific limitations, constraints or prohibitions regarding treatment other than:

_____

_____

_____

Patient Signature_____ **Date**_____

Surgeon Signature_____ **Date**_____

Witness Signature_____ **Date** _____

If you are consenting to the care of another: I have the legal authority to sign this on behalf of:

Patient Name_____ Your relationship to patient_____

_____

Signature of legal guardian Date Witness signature

Changes in treatment plan:

_____

_____

Patient Signature_____ Date_____

Surgeon Signature_____ Date_____

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ATTACHMENT FOR

PERIODONTAL/IMPLANT INFORMATION AND CONSENT FORM

- **Allograft** - Human bone is from properly screened donors. Each individual donor history is carefully reviewed to reduce the possibility of disease transmission. FDA approved tests are conducted on all bone grafts for presence of Hepatitis B and C, HIV (AIDS) and Syphilis. Currently these are the only transmissible diseases evaluated and may not be inclusive of other more remote transmissible diseases. The bone is extensively treated with various sterilization methods to remove all blood products and contaminants. The bone is packaged in vacuum sealed sterile containers.

- **Xenograft (Bovine)** - This bone is taken from bovine (cow) sources. Bovine bone is nonantigenic and properly prepared and sterilized by FDA approved methods. This bone is physically and chemically comparable to human bone. The structure of this bone graft supports growth of the patients own bone and used when the patient's own bone is deficient.

- **Bone or Tissue Growth Factors** - Naturally occurring or genetically engineered proteins or hormones that stimulate cell growth and function. These proteins are naturally found in both human and animals and have been scientifically shown to promote wound healing. Proteins have been scientifically demonstrated to stimulate cells in the bone and tissues surrounding the tooth. Studies have shown the regeneration of periodontal tissues including bone, cementum and periodontal ligament. Growth factors are aseptically processed and sterilized by FDA approved tests.

- **AlloDerm or Dermis Allograft** - Dermis allograft consists of human collagen. Comprehensive donor screening and testing is performed according with FDA regulations. Each tissue is being tested for presence of relevant communicable diseases such as Hepatitis B and C, HIV(AIDS) and Syphilis. The tissue graft is also tested for bacterial and fungal pathogens. The tissue graft is then processed with various sterilization methods to remove all donors' blood and tissue cells. Due to limitation in testing technology, testing and donor screening cannot totally eliminate the risk that the tissue graft will transmit disease. The tissue graft is shipped in sealed sterile containers packaged for individual use.

Initial this attachment and sign knowledge of consent form on page 3 ⇨

Initials: _____

Date: _____

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