SOUTHERN CALIFORNIA CENTER FOR ORAL AND FACIAL SURGERY
JAY B. REZNICK, D.M.D., M.D., INC.
818-996-1200

CONSENT FOR DENTAL IMPLANT SURGERY AND ANESTHESIA

Patient: _____ Chart #: _____ Date: _____

Proposed implant type and number: _____

Type of anesthesia: _____

PLEASE INITIAL EACH SECTION INDICATIONG THAT YOU UNDERSTAND THAT PORTION OF THIS CONSENT FORM:

_____ 1. I have discussed with Dr. _____ concerning the type of implant system that will be used. I have been informed of the advantages and disadvantages of this system and of the intended purpose for implants.

_____ 2. I have further been informed of possible risks and complications associated with the surgical procedure. These include, but are not limited to, full or partial, temporary or permanent numbness of the lip, tongue, cheek, chin, gum tissue or teeth; injury to adjacent teeth, fracture of the jaw, limited jaw opening, sinus penetration, infections, prolonged bleeding, pain, sensitivity, delayed healing of the surgical site, and swelling and bruising of the facial tissues.

_____ 3. I understand that if no treatment is rendered at this time, any of the following may occur: further loss of bone (making it impossible to place implants in the future), continued irritation and inflammation of gum tissue, sensitivity, loosening or infection of teeth, followed by necessity for extractions or improper chewing function due to missing natural teeth, which may result in temporomandibular joint problems.

_____ 4. I understand that smoking, alcohol, or increased sugar consumption will affect tissue healing, which will alter the prognosis of the implants after placement.

_____ 5. I have been informed and understand that implant surgery is a complex and intricate procedure and that there is a risk of implant failure. There were no guarantees or assurances made as to the outcome of treatment or surgery.

_____ 6. I understand that certain possible risks exist with the use of sedative drugs and local and general anesthetics that, although uncommon or rare, could include nausea, pain, swelling, inflammation, infection and/or bruising at the injection site. Rare complications could include nerve damage, allergic or idiosyncratic drug reactions, pneumonia, heart attack, stroke, brain damage and/ or death.

_____ 7. I agree and understand that I am not to have and/or have not have anything to eat or drink for six hours before my surgery if I am having intravenous sedation or general anesthesia.

_____ 8. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle, automobile or hazardous device, make important decisions, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

_____ 9. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

_____ 10. It is now appreciated that antibiotics will inactivate most birth control pills. Sexually active women who take birth control pills should use another method of contraception for the remainder of the menstrual cycle if antibiotics are prescribed.

_____ 11. I consent to clinical photographs, filming or x-rays of the procedure for necessary documentation and/or teaching

purposes.

_____12. Other: _____

_____

I consent to administration of such local and/or general anesthesia or sedation as deemed necessary by the surgeon and/ or his designated assistants to accomplish the proposed procedure. Typically the effect of general anesthesia or sedation is described as being "asleep" during the surgery or procedure. The medications used generally cause amnesia (forgetfullness) of the surgery and the surrounding events. This amnesia is temporary. The doctor and treatment team are trained in the use of anesthesia and the treatment of complications. The patient's condition during anesthesia will be monitored by the doctor, staff, and by mechanical and electronic methods.

If I am having general anesthesia or intravenous sedation, I agree and understand that I am not to have and/or have not have anything to eat or drink for six hours before my surgery. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle, automobile or hazardous device, make important decisions, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic or sedative drug.

If any unforeseen condition should arise or findings be discovered in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable. This includes sending tissues and/or fluids to an outside laboratory for examination, even if this had not been previously discussed.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss with the doctor my past medical and health history including any serious problems and/or injuries. I certify that I have not omitted or concealed any significant facts regarding my past or present health.

I agree to cooperate completely with the recommendations of my surgeon while I am under his care, realizing that any lack of same could result in a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS, WORDS AND EXPLANATIONS WITHIN THE ABOVE CONSENT TO THE OPERATION PROPOSED, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

_____ _____

Patient, Parent or Guardian Date

_____ _____

Witness Date

_____ _____

Doctor Date