

INFORMED CONSENT

IMPLANT TREATMENT

Dr. Burchfield has explained the benefits and risks of dental implants to me. I understand that implants involve the placement of a Titanium Cylinder into the bone. I further understand that implant treatment is complex and includes the need for proper prosthetic restoration. I also understand that the placement of the implant device and associated risks are separate from the restoration of the implant and associated risks.

I understand the number and location of implant devices will depend on the availability of adequate bone to support the implant and the number of teeth that need to be replaced. There may be involvement of the sinus cavities when the implants are placed in the upper jaw. Alternative treatments have been explained to me. It has been explained to me that one option is to do nothing. I understand the risks of no treatment may include, but are not limited to: loss of bone and gum tissue; jaw joint problems, headaches and referred pain; sensitivity, inflammation and infection.

I understand and accept the treatment recommended for me by Dr. Burchfield. I further understand that there may be some unwanted complications, some of which are listed below. No guaranties have been made or implied. I also understand that implant supported prosthesis requires continuing professional monitoring, may require additional treatment in the future, and success is dependent upon home care. I realize implants may become loose and need to be removed or replaced. All of my questions have been addressed.

Proposed fees have been explained to me, as have any third party insurance benefits. I understand that third party benefits may be different than discussed by Dr. Burchfield as they are not under the control of this office.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications / anesthetic
- **Temporary or permanent numbness or tingling** of the lip, chin, face, tongue and gums
- Damage to nearby teeth and restorations
- Post treatment bleeding
- Post treatment infection
- Post treatment tissue swelling
- Sensitivity, pain
- Aesthetic result (disagreement involving appearance)
- Failure to implant integration

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO TREATMENT DESCRIBED IN THIS PAPER.

Patient Signature _____ Date _____

Witness _____ Date _____