Goehring Dental
Dennis P. Goehring, D.D.S., P.A.
Luana Badea, D.D.S., F.A.G.D.
4407 Manchaca Rd.
Austin, Tx. 78745
Office: 512-892-8822
Fax: 512-899-1290

Implant Placement Consent

Diagnosis:

Dr. Dennis Goehring/Dr. Luana Badea has advised me that the diagnosis of my condition is a tooth/teeth which must be/have been removed and a desire on my part to replace the tooth/teeth with an implant crown/crowns or implant supported prosthesis/prostheses (partial dentures, full dentures, or bridgework).

Recommended Treatment:

I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removable denture or bridge.

My gum tissue will be reflected and an opening will be created in the jaw where the implant will be placed. The choices available for pain management during the procedure are: (1) local anesthetic only, (2) local anesthetic with "laughing gas" or (3) local anesthetic with intravenous conscious sedation. Local anesthesia alone generally has the smallest risks associated with it and local anesthetic with intravenous conscious sedation has the greatest risks.

I understand that if the bone adjacent to the proposed site of the dental implant is not adequate that a bone grafting and/or regenerative procedure may be necessary. If completed these procedures sometimes involve a second surgical procedure that will be scheduled several weeks following the initial surgical visit. This second surgical visit will be planned at a time that Dr. Goehring/Badea feels is appropriate based on my healing. Even without the bone grafting/regenerative procedures a second stage surgery is necessary for the implant site to uncover the implant and place the initial attachment and allow the restorative/prosthetic procedures to be pursued.

Expected Benefits:

Placement of the implant will allow for replacement of my missing tooth/teeth by a cemented, screw retained, or removable appliance.

Principal Risks and Complications:

I understand that although complications are rare, unforeseen conditions may call for changes in the anticipated surgical plan. I understand that I consent to any such changes as deemed indicated in the opinion of Dr. Goehring/Badea. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: the need for additional dental work, or the modification of the planned dental work. Some complications could include the need for a referral to other dental or medical specialists.

The success of implant placement procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to Dr. Goehring/Badea any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that I have now or have had at any time in the past.

I understand that complications may result from the surgery and/or any drugs used. <u>These complications may include, but are not limited to:</u>

1. Pain and swelling of the surgical area, ear, neck and head that may require several days of at home rest. Temporary bruising of the face, neck, eye and mouth may also occur.
2. Injury to the nerve branches resulting in numbness and tingling of the: lower eyelid, upper/lower lip, side of nose, chin, cheek, gums, palate, and/or teeth, which may be temporary or permanent.
3. Infection that might require further treatment, including removal of the implant, hospitalization and surgery.
4. Failure of the implant to attach to the bone can lead to the need for additional procedures to include, but not limited to: placement of another implant, bone grafting, gum grafting, or a decision not to place the implant.
5. Smokers should not smoke one day prior to surgery, the day of surgery and one day following surgery. Not smoking one week prior and two weeks following surgery is greatly preferred.

6. Injury to the teeth or roots to include, but not limited to: tooth loss, tooth looseness and sensitivity to hot, cold, sweet or acidic foods, which may require root canal treatment.
7. Bleeding that may require blood transfusions or other means to control.
8. During the procedure and postoperatively, there may be unfavorable reactions to local anesthetics and drugs, such as nausea, vomiting, and allergy, changes in breathing pattern, heart rhythm and/or blood pressure, and the possibility of brain damage and/or death in extreme cases. I understand Dr. Goehring/Badea will utilize appropriate monitoring of my heart, blood pressure and breathing based on the techniques and drugs used and I accept the potential risks described above. I understand that if such complications occur additional care will be necessary.
9. Restricted mouth opening, pain in the joint that hinges the jaw, limitation of jaw function or stiffness of facial and jaw muscles.
10. Shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth.

Alternatives to Suggested Treatment:

-No treatment
-Bridge
-Partial denture
-Full denture

Necessary Follow-Up and Self-Care:

It is important for me to: (1) abide by the specific prescriptions and instructions given by Dr. Goehring/Badea and (2) see my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. I also need to inform Dr. Goehring/Badea as soon as possible of any complications or symptoms that may relate to the implant placement**.**

No Warranty or Guarantee:

It is understood that although good results are expected, I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. Its long-term success and potential risks and complications may not be fully known.

I have read this entire form and understand everything explained in it:

I understand that anesthetics, medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing those risks, I accept full responsibility for informing Dr. Goehring/Badea of a suspected or confirmed pregnancy understanding this could require the procedure be rescheduled. For the same reasons, I understand I must inform Dr. Goehring/Badea if I am a nursing mother. Therefore, I certify that I am not currently pregnant and do not suspect I am pregnant at this time. I have also been informed that some antibiotics may interfere with the effectiveness of some birth control medications. With this in mind I certify that I have informed Dr. Goehring/Badea if I am using birth control medication. If I am, Dr. Goehring/Badea has advised me to practice abstinence or utilize caution and/or additional preventative measures during the time the prescribed medications or drugs could affect the birth control medication's effect.

I certify that I have read and understand English or this form has been translated to me. I have had the opportunity to ask Dr. Goehring/Badea about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative methods. Dr. Goehring/Badea has answered all my questions.

I hereby authorize Dr. Goehring/Badea to perform implant placement at the following location(s):

Patient _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date_____