INFORMED CONSENT FOR
ROOT FORM DENTAL IMPLANTS

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DIAGNOSIS After a careful oral examination and study of my dental condition, Dr. Williamson has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant.

RECOMMENDED TREATMENT In order to treat my condition, Dr. Williamson has recommended the use of root form dental implants. I understand that the procedure for root form implants involves placing implants into the jawbone. This procedure has a surgical phase followed by a prosthetic phase.

SURGICAL PHASE OF PROCEDURE I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will have to be snugly fitted and held tightly in place during the healing phase. The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of four to six months. I understand that dentures usually cannot be worn during the first one to two weeks of the healing phase. I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, Dr. Williamson will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby assist in placement, closure, and security of my implants. For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance can then begin.

PROSTHETIC PHASE OF PROCEDURE I understand that at this point I will be referred back to my dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic device will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.

EXPECTED BENEFITS The purpose of dental implants is to allow me more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

PRINCIPAL RISKS AND COMPLICATIONS I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to post surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to teeth, bone fractures, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible. I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter. **I will inform my dentist if I am taking or have taken bisphosphonate drugs in the past. I understand that if I am taking oral bisphosphonates, several complications can occur after having this type of procedure and I have discussed it with my dentist.**

ALTERNATIVES TO SUGGESTED TREATMENT Alternative treatments for missing teeth include no treatment, new removable appliances, in some cases fixed bridges, and other procedures — depending on the circumstances. However, continued wearing of ill fitting and loose removable appliances can result in further damage to the bone and soft tissue of my mouth.

NECESSARY FOLLOW-UP AND SELF-CARE I understand that it is important for me to continue to see my dentist or prosthodontist. Implants, natural teeth and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by Dr. Williamson.

NO WARRANTY OR GUARANTEE I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences a periodontist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best of care. If for some reason the implant does not attach to the bone and the cause of the failure is not due to factors within my control (i.e. smoking, trauma, lack of proper care or follow up, etc.), Dr. Williamson will do a second implant at no cost to me. If I choose not to have the second implant procedure or if the second implant also fails I understand that I will not receive any financial reimbursement.

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PUBLICATION OF RECORDS I authorize photos, including those of my face, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry or for reimbursement purposes. My name, however, will not be revealed to the general public without my permssion.

CONSENT FOR SEDATION I understand that anesthetics, medications, and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Mike Williamson of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the procedure. For the same reason I understand that I must inform Dr. Mike Williamson if I am a nursing mother. Because medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can increase with the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least 24 hours or longer until recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any major decisions until after recovery from anesthesia and will have a responsible adult accompany me until I am fully recovered. I have been informed to not drink alcohol or take other nervous system depressants for 24 hours following medication administration. I have been fully advised of and completely understand the alternatives to sedation and accept the possible risks and dangers. I acknowledge the receipt of and understand the preoperative instructions given to me. It has been explained to me and I understand that there is no warranty of guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and am satisfied with the information provided to me. I acknowledge that the options for sedation including local anesthesia and conscious sedation have been explained to me. I consent, authorize and request the administration of such anesthetics. I have been made aware of the potential complications associated with the sedation including but not limited to nausea, vomiting, allergic reaction, fluctuations in breathing patterns, heart rhythm and or blood pressure; brain damage and even death. I authorize any corollary procedure, including hospitalization that is necessary to manage my case.

I have been fully informed of the nature of root form implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Williamson. After thorough deliberation, I hereby consent to the performance of dental implant surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to use of an alternative implant system or method if clinical conditions are found to be unfavorable for the use of the implant system that has been described to me. If clinical conditions prevent the placement of implants, I defer to Dr. Williamson's judgment on the surgical management of that situation. I also give my permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in placement, closure, and security of my implants. I authorize that my treatment and/or financial information may be discussed with family members, guardians, or accompanying chaperones.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT:

SIGNATURE of patient, parent, or guardian

Date

SIGNATURE of witness

Date