Nina V. Aks, D.M.D.
General, Cosmetic & Implant Dentistry

20500 Seneca Meadows Pkwy, Suite#2220
Germantown, MD 20876

Phone: (301) 916-8570
Fax:: (301) 916-8579

PATIENT INFORMED IMPLANT CONSENT

First Name:_____ Last Name: _____ DOB: _____ /_____ /_____

SURGICAL PROCEDURE: _____

_____

I have been informed and I understand the purpose and the nature of the implant procedure. I understand what is necessary to accomplish the placement of the implant under the gum of the bone.

My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible is inflammation of a vein, injury to teeth, bone fractures, sinus penetration, delayed healing, or allergic reactions to drugs or medications used.

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

My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities of each patient following the placement of the implant.

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.

I understand that smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

I agree to the type of anesthesia, depending on the choice of the doctor. If sedative drugs and narcotics are used, 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.

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 blood diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I consent to photography, filming, recording and x-ray of the procedure to be performed for the advancement of implant dentistry provided my identity is not revealed.

I request and authorize medical/dental services for me including implant and other surgery. I fully understand that during and following the contemplated procedure, surgery or treatment conditions may become apparent which warrant, in the judgement 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 in my best interest.

I HAVE HAD AN OPPORTUNITY TO READ THIS FORM, ASK QUESTIONS AND HAVE MY QUESTIONS ANSWERED TO MY SATISFACTION. I HEREBY CONSENT TO THE PLACEMENT OF IMPLANTS IN MY MOUTH.

Signature of Patient _____ Date _____

As a courtesy for our patients, if implant fails within first year of placement, we will replace the implant free of charge. Patient will be responsible for the cost of used materials (bone and membrane) if applicable.
Patient was informed that the warranty doesn't apply if:

- **Patient is a smoker;**
- **Patient doesn't follow prescribed protocol for follow up;**
- **Patient doesn't follow doctor's instructions.**

Signature of Patient _____ Date _____

Patient was informed that Dr. Liu is an independent contractor in our office. Dr. Liu is not our employee. He is in control of any decisions regarding patient treatment.

Signature of Patient _____ Date _____

FOLLOW-UP PROTOCOL FOR IMPLANT PROCEDURE

Patient agrees to follow protocol for implant procedures:

1. 1 week- follow-up visit after surgery (x-ray if necessary).
2. 2 weeks- follow-up visit after surgery (x-ray if necessary).
3. 2 month- follow-up visit after surgery with x-ray.
4. 4 month- follow-up visit after surgery with x-ray.
5. 6 month- second stage (open implants) with x-rays.
6. 7-10 days -2nd stage follow- up visit and stitches removal if necessary.
7. 3-4 weeks- Impression for restorative work.
8. 3 month follow-up visit after restoration with x-ray.
9. 6 month follow-up visit after restoration with x-ray.
10. 12 month follow-up visit after restoration with x-ray.
11. 18 month follow-up visit after restoration with x-ray.
12. 24 month follow-up visit after restoration with x-ray.
13. Once a year follow-up visits thereafter with x-rays.

Signature of Patient _____ **Date** _____