Consent for ALL ON Surgery and Temporization
Dr. Allen Aptekar

Patient:

Implant Site(s): _____

1.I have been informed and afforded time to fully understand the purpose and the nature of the implant surgery and ALL ON procedure. I understand what is necessary to accomplish the placement of the implant(s) under the gum and in the bone, and then immediately attach temporary fixed bridge to the implants.

2. I have been fully formed and explained that any remaining teeth in my upper and/or lower jaw will be extracted; bone will be removed to make things level and provide space for the prosthesis. Then the implants will be placed, and a temporary fixed bridge will be secured to the implants. I have also been explained that in rare instances, if a certain amount of stability is not reached with the implants, a temporary fixed bridge cannot be attached, and I may leave wearing a traditional complete denture, and will wear this denture for up to 6 months while the implants heal in my jaw.

3. I have been informed that Dr. Allen Aptekar is a dental surgeon (general dentist).Dr. Allen Aptekar has carefully examined my mouth. Alternatives to this treatment have been explained. These alternatives are other dental implant based options, denture(s) and/or fixed bridge(s), or no treatment of any kind. I have tried or considered these methods, but I desire the ALL ON implant procedure to help secure the replaced missing teeth.

4. I have further been informed of the possible complications and risks involved with surgery, drugs and anesthesia. I understand and accept these possible complications and risks. Such complications can include but are not limited to 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 are inflammation of the veins, injury to teeth present, bone fracture, sinus penetration, delayed healing, allergic reaction to drugs or medication used.

5. I understand that if nothing is done any of the following could occur: bone loss, gum tissue inflammation, infection, and sensitivity, looseness of teeth followed by necessary extraction. Also possible are temporomandibular joint (jaw) problems, headaches, and referred pains to the back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.

6. My doctor has explained that there is no method to predict accurately the gum and bone healing capability in each patient following the placement of the implant. In general a healing time of 3-6 months is normal. There are instances where implant treatment may not succeed. Alternatives will then be readdressed.

7. I have been fully explained, told, and completely understand that I am too follow a strict soft food diet for the first 6 weeks to give the best chance at optimal healing of my bone, tissue, and implants, as well as avoid possible fracture of my temporary fixed teeth.

8. It has been explained to me 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 or results of the treatment or the surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant(s) with possible corrective surgery associated with the removal.

9. I understand that excessive smoking; alcohol use or blood sugar problems may affect gum and bone healing and may limit the success of the implant(s). I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

10. I agree to the local anesthesia, depending on the choice of my doctor. If I have chosen in addition to local ansthesia, a form of sedation, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more or until fully recovered from the effects of the anesthesia or drugs given for my care.

11. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergies or unusual reactions to drugs, insect bits, anesthetics, pollen, dust, blood or body disease, gum or skin reaction, abnormal bleeding or any other conditions related to my health.

12. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be preformed for the advancement of implants dentistry, provided my identity is not revealed.

13. I agree to notify my doctor's office of any and all changes to my address and/or telephone number within a reasonable time frame (two to four weeks).

14. I request and authorize medical/dental services for myself, including implants and other surgery. I fully understand the contemplated procedure. I approve any modifications in design, material, or care, if it is felt this is for my best interest. If any unforeseen conditions arise in the course of the treatment which calls for the procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, associates or assistants, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.

15. In rare instances implant treatment does not succeed including the surgery or prosthetics due to biological factors beyond our control or ability to predict. In these circumstances we may offer alternative treatment. The patient is still responsible for any materials cost incurred with the additional treatment. This in no way implies that we have provided inadequate professional treatment but our desire to see you have the best possible outcome.

16. There have been recent studies that may link bisphosponate medications with severe bone infections following dental surgery. Examples of this class of medication include Fosomax, Zometa, Didronel, Aredia, Actonel and Boniva. If you are taking any of these medications please bring this to our attention so that we may discuss how this may impact on the proposed surgery.

I _____ certify that I have fully read and fully understand all of the above information and have been fully informed of the nature of dental treatment along with possible risks and complications and by signing below hereby consent to treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Doctor Signature: _____ Date: _____