

**SEDATION DENTISTRY NW**  
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**CONSENT FOR DENTAL IMPLANTS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

You have the right and obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. I request and authorize Dr. Powell or his/her associates to perform the surgical placement of dental implant(s) upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

Dental implants are metal anchors placed inside the jawbone underneath the gum line. Small posts are attached to the implants and artificial teeth or dentures are fastened to the posts.

Most patients need two surgical procedures to place the implants and accompanying fixtures. The first procedure involves drilling small holes into the jawbone and placing the implant body. A temporary denture may be worn for a few months while the implant fully integrates with the bone and gums. The second procedure will uncover the implants to allow for attachments of the posts. After the posts are in place, the replacement teeth are fastened to the posts. The replacement teeth may be a crown, bridgework, or a removable denture. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also might be necessary at the time of implant placement.

The potential benefits of this procedure include the replacement of missing natural teeth or the stabilization of dentures.

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition which may include no treatment at all, complete or partial dentures, or fixed or removable crowns and bridges. Each of these alternative forms of treatment has its own potential benefits, risks, and complications.
3. I consent to the administration of anesthesia or other medications before, during, or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications involve the very rare potential of paralysis; cardiac arrest; and/or death from both known and unknown causes.
4. I understand that there are potential risks, complications, and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complications and side effects, I have been informed of some of the potential risks, complications, and risks of dental implant surgery. These could include but may not be limited to the following:
  - Postoperative discomfort and swelling
  - Bleeding
  - Postoperative infection
  - Injury or damage to adjacent teeth or roots of teeth
  - Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums, and tongue

- Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw – temporomandibular joint (TMJ) syndrome
- Fracture of the jaw
- Bone loss of the jaw
- Penetration into the sinus cavity
- Mechanical failure to anchor, posts or attached teeth
- Failure of the implant itself
- Allergic or adverse reaction to any medications

Most of these risks, complications, and side effects are not serious or do not happen frequently. Although these risks, complications, and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications, or side effects.

These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical, surgical treatment or procedures, hospitalization, or blood transfusions. Very rarely, the potential risks and complications could result in permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment as required.

5. **While the vast majority of implants are successful – greater than 90%, there could be a failure of an implant. If failure results, after biological stability of the implant site is obtained, the implants will be replaced at no charge if the patient desires. There may be factors unknown by patient/provider which result in an environment where there will never be implant success. In such cases, every option will be exposed to reach an equitable outcome for the patient. However, refunds from the insurance company or the office will not be possible. \_\_\_\_\_(initial here)**
6. I certify that I have read or have had read to me, the consents of this form and will follow any patient instructions related to this procedure. I understand the potential risks, complications, and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risk, complications, side effects, and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

\_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_ Date: \_\_\_\_\_  
*Printed name if signed on behalf of patient*