CASCADE FAMILY DENTAL

IMPLANTS AND IMPLANT PROSTHETICS

I UNDERSTAND that IMPLANTS AND PROSTHODONTIC DEVICES (crowns, bridges, dentures) placed over implants include possible inherent risks such as, but not limited to the following and I agree to assume any and all such risks:

1. **Possibility of failure of implants:** No matter how diligently and carefully the surgery necessary to the placement of implants and implant devices is performed, there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices. Also, not all body tissues accept the materials from which implants are constructed and there may be rejection of the appliance(s), infection and non-healing of the tissues. In such cases, removal will in all probability be necessary.

2. **Longevity of implants and/or accompanying prosthesis:** There can be no positive or even potential determinations as to the life expectancy of implants, crowns, and/or fixed or removable bridgework because of the many variables which are not within the treatment provider's control.

3. **Infection:** In spite of how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile environment, infections may occur postoperatively. At times these may be of a serious nature. Should severe swelling occur, particularly when accompanied with fever or malaise, attention should be received as soon as possible. It is the patient's responsibility to contact this office should the foregoing occur. Such infection may necessitate removal of the affected implant or implants.

4. **Injury to the nerves:** There is the slight possibility of injury to the nerves of the face and tissues of the oral cavity during administration of local anesthetic or during implant placement which may cause numbness of lips, tongue, floor of the mouth, and or cheeks, etc. This numbness may be of a temporary or, rarely, permanent in nature.

5. **Excessive smoking, alcohol intake or diabetes:** These factors may adversely affect the healing process, limiting the resulting success of the implants and accompanying prostheses.

6. **Follow-up examinations:** It is absolutely necessary with implant therapy to have regular periodic examinations. The patient must assume the responsibility to make appointments and report as instructed by the treating dentist(s) or staff.

7. **Placement:** It is possible that ideal implant placement may not be possible based on anatomic limitations and esthetic and functional compromises may have to be made during the process of completing dental restorations. Even ideal implant placement may be tempered by restorative problems. Well-integrated implants may become loose and fail years after placement.

8. **Unusual reactions to medications given or prescribed:** Reactions, from mild to extremely severe, may possibly occur from anesthetics or other medications administered or prescribed.

9. **Bisphosphonate drug risks:** For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone, including the placement of implants. There is thus an increased risk of failure of the implant due to delayed or failed osseointegration or growth of healthy bone around the implant.

10. **I recognize that it is my responsibility to fully inform my treating dentist(s) of the condition of my health and any and all problems thereto. It is also my responsibility to timely seek attention**

should any undue circumstances occur postoperatively. I agree to diligently comply with any and all preoperative and postoperative instructions given me.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of the implants and prosthetics relating to implants and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and/or any results from the treatment to be rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize the Doctors of Cascade Family Dental involved in rendering any services he/she deems necessary or advisable to treatment of my dental conditions, including any anesthetic agents and medications.

Patient's name (please print)	Signature of patient, legal guardian, or authorized representative	Date
	Witness to signature	Date

_____Treatment Alternatives

_____Advantages of Each Alternative

_____Disadvantages of Each Alternative

_____Risk of Each Alternatives

_____Costs of Each Alternatives

_____Results of Doing Nothing