**IMPLANT INFORMATION AND CONSENT FORM**

I have been informed and I understand the purpose and nature of implant supported dentistry. I understand that is necessary to accomplish the placement of the implant supported denture or tooth replacement.

Dr. Trotter has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire the placement of implants to help secure the replaced missing teeth.

I will be consulting with Dr. Jokay regarding the possible risks and complications involved with the placement of the implants, drugs and anesthesia. I have been informed by Dr. Trotter of the possible complications of broken posts or abutments and failure of the teeth if the implants fail. However, the success rate of dental implants stands at approximately 95% at 20 years.

I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, and looseness of teeth followed by extraction. Also possible are temporomandibular joint (jaw) problems, headaches and tired muscles when chewing.

Dr. Trotter has explained to me that there is no method to accurately predict gum and bone healing capabilities in each patient following the placement of the implants.

It has been explained that in some unusual instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science: no guarantee or assurances as to the outcome of the results of treatment or surgery can be made.

I understand that excessive alcohol, smoking or sugar may affect gum healing and limit the success of the implants.

I agree to follow home care instructions. I agree to report to Dr. Trotter and/ or my regular dentist for regular follow- up. How I take care of my implants and artificial teeth on a daily basis goes a long way toward the health of the implant.

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 food, drugs insect bites, anesthetics, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry.

I request and authorize 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 judgment of the dentist, 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 for my best interest.

I have been informed of the approximate number of appointments needed and the given time frame to complete my artificial implanted supported denture or tooth replacement.

I have been informed of the approximate costs. I realize that this is only approximate since the construction of my implant teeth will begin 4-6 months after surgery.

Dr. Trotter has informed me that she will be financially responsible for all adjustments and repair up to two (2) years after insertion. After this date, I will be responsible for all costs (professional and lab costs). I will be responsible for the costs of the one year follow up appointment.

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_