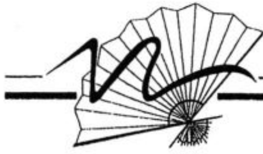

Clifton E. Nakatani DDS MSD
Practice Limited to Periodontics and Implants

CONSENT FOR DENTAL IMPLANTS

PURPOSE OF IMPLANTS: I have been informed that the purpose of an implant is to provide support for a crown (artificial tooth) or a fixed or removal denture or bridge.

ALTERNATIVE TREATMENT: Reasonable alternatives to implants have been explained to me. I have tried or considered these methods, but I desire an implant to help secure the replaced missing tooth/teeth.

TYPE OF IMPLANT: I am aware that the type of implant(s) to be used on me is one which is placed into the jawbone; that this is done by first reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone, and finally covering the bone and implant with the gum flap.

SURGICAL PROCEDURES: I understand that multiple surgeries may be necessary. One to insert the implant(s) as described above and one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge, or denture. I also understand that sometimes it is beneficial to add gum tissue to the implant site either prior to implant placement or after the implant(s) has healed. I also understand that sometimes the implant is covered with a bone graft material or a membrane to further enhance healing and that this may necessitate an additional procedure to remove the membrane.

RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to the surgery include, but are not limited to, post surgical infection, bleeding, swelling, pain, facial discoloration, upper jaw sinus or nasal cavity perforation during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth or chin, jaw joint injuries or associated muscle spasm, bone fractures, and slow healing. Prosthetic risks include, but are not limited to, unsuccessful union of the implant(s) to the jaw bone, stress metal fracture of the implant(s). If any of these occur, a separate surgical procedure would be necessary to remove the failed implant(s). Risks related to the anesthetics include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, inflammation, soreness, discoloration or blockage along a vein at the injection site.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed or any other reasonable alternative treatment, that such a decision is my sole responsibility. I acknowledge that risks related to my non-acceptance of treatment for my problem have been explained to me and include, but are not limited to, dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bone, further gum recession, problems with my bite including pain, spasm, headaches, or problems with my jaw joints or associated musculature.

ANESTHESIA

☒ Local anesthesia will be used.

☐ Local anesthesia with oral anti-anxiety medication. **If you take this medication, YOU CANNOT DRIVE. You will need a driver to stay in our office for the duration of the surgical visit.**

ANESTHESIA RISKS include discomfort, swelling, bruising, infection, prolonged numbness, and/or an allergic reaction.

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.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be completely successful in function or appearance (to my complete satisfaction). It is anticipated (hoped) that the treatment will be permanently retained but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long term success cannot be promised.

CONSENT TO UNFORSEEN CONDITIONS: During treatment, unknown conditions may modify or change the original treatment plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant(s). I, therefore, consent to the performance of such additional or alternative procedures as may be required by proper dental care in the best judgment of the treating doctor.

INITIAL X________

1102 Corporate Way • Suite 150 • Sacramento, CA 95831
916-421-5555

RESPONSIBILITY FOR PROSTHETIC SUCCESS: I understand that the fabrication and attachment of prosthetic devices (attachments and tooth replacements) will be the responsibility of another dentist. I further understand that the long term maintenance, repair, and success of these devices will be the sole responsibility of the dentist who provides this prosthetic care.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I agree to diligently comply with any and all pre-operative and post-operative instructions given to me. I understand that if I need to and don't return for my follow-up visits, my condition may get to a point where I might need more care or more surgery. I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my treatment. It is my responsibility to timely seek attention should any undue circumstances occur post-operatively. I agree to report for post-operative care appointments following my treatment so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of my treatment upon completion of and so that Dr. Nakatani can evaluate and report on the outcome of the surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to the procedure. I give consent that my records may be used for educational use in lectures or publications provided that my identity is NOT revealed.

SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and/or reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of periodontal dentistry prior to completing my deliberation and decision.

BLOOD CONCENTRATES: I give my consent to use my own blood in the surgical procedure utilizing my blood concentrate. The amount of blood drawn for this procedure is approximately 20-60 cc's.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of this procedure and have received answers to my satisfaction. I recognize that it is my responsibility to fully inform Dr. Nakatani of the condition of my health and any and all problems thereto. 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 rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, (1) certifies that I have read and understand the entirety of this document and (2) I am freely giving my consent to authorize Dr. Nakatani and/or all associates involved in rendering any services he/she deems necessary and advisable to treatment of my dental conditions, including any anesthetic agents and medications.

X ______________________________
Name of Patient (Please Print)

X ______________________________ X ________________
Signature of Patient or Legal Guardian Date

As a part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

Clifton E. Nakatani DDS MSD INC. ______________________________ Witness