Brian Mitchell, D.D.S.

SURGICAL IMPLANT INFORMED CONSENT

Because of the wide differences among people and dental conditions, a successful outcome cannot always be obtained. Dentistry is not an exact science and no guarantees or assurance as to the outcome of treatment or surgery can be made.

Dr. Mitchell has examined my mouth and alternatives to this treatment have been explained. To my knowledge, I have given an accurate report of my physical/mental health history to Dr. Mitchell. I have also reported any prior allergic or unusual reactions, abnormal bleeding or any other conditions related to my health.

I HAVE BEEN INFORMED OF THE POSSIBLE RISKS AND SUCH COMPLICATIONS INCLUDING:

Pain, swelling, infection and discoloration of gum tissue

Numbness of the lip, tongue, chin, cheek, teeth or other areas may occur (the exact duration

may not be determinable and may be irreversible).

Inflammation or injury to the adjacent teeth present, bone fractures, sinus penetration, delayed

healing and allergic reactions to drugs or medications used.

Smoking, alcohol, or excessive sugar may affect gum healing and may limit the success of the implant. I agree to follow Dr. Mitchell's home care instructions and will report to his office for regular examinations as instructed.

I understand what is necessary to accomplish the placement of the implant under the gum and in the bone. Recognizing there is no method to accurately predict the gum and/or bone healing capabilities following the placement of the implant, and it has been explained that in some instances implants fail and must be removed. **In the event that the body rejects the implant, Dr. Mitchell will replace the implant at 50% of the current fee. This does not include any necessary bone grafts and/or additional surgeries to correct any bone deficiencies. There will be no refunds issued if the patient elects not to place a second implant.**

I request and authorize permission for implant surgery and fully understand that during and/or following the treatment, conditions may become apparent which warrant, in the judgment of Dr. Mitchell, additional or alternatives treatment pertinent to the success of the implant. I also give authorization to release patient information to other healthcare providers, and other involved parties as deemed appropriate by your office. I also approve any modifications in the procedure or materials used if it is felt necessary.

I have been given the opportunity to ask questions about this procedure and am fully satisfied with the answers I received.

Signature of the Patient_____**Date**_____
(If the patient is a minor, then signature of parent or legal guardian is requested.)

Signature of the Witness_____**Date**_____