NY IMPLANT DENTISTRY
Greg Diamond, DDS
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PERIODONTICS, AESTHETIC AND IMPLANT DENTISTRY

Implant Patient Consent Form

I have been informed and understand the purpose and the nature of the Implant Surgery Procedure. I understand what is necessary to accomplish the placement of the Implant under the gum and in the bone.

Dr. Diamond has carefully examined my mouth. Alternatives to this treatment have been explained. I have considered all alternatives, although, at this point, I desire implants to help secure and replace my missing teeth.

I have further been informed of the possible RISKS and complications associated with surgery, Medications and Anesthesia. Such complications include pain, swelling, infection, and discoloration. Numbness of the lip, tongue, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications used.

I understand that IF NOTHING IS DONE, any of the following could occur: bone disease, loss of bone, tissue inflammation, infection sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are Temporomandibular Joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles from chewing.

Dr. Diamond has explained that there is not a method to accurately predict the gum and bone healing capabilities in each patient, following the placement of the implant.

It has been explained that in some 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 assurance as to the outcome of results of treatment or surgery can be made.

I understand that excessive smoking or alcohol, may effect the healing of the tissue, and may limit the success of the implant. I agree to follow Dr. Diamond's home care instructions. I agree to report to Dr. Diamond's office for regular examinations as instructed.

I agree to the type of Anesthesia, depending on the choice made by Dr. Diamond. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia (Should I.V. sedation be administered) or medications given for my care.

To my knowledge, I have an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, food, insect bites, Anesthesia, pollens, 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 o Implant dentistry, provided my Identity is not revealed.

I understand and authorize medical/dental services for me, including Implants and other surgery. I fully understand that during and following the complicated procedure, surgery or treatment, conditions may become apparent which warrant in the judgment of Dr. Diamond, 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 this is for my best interest.

Signature of Doctor_____Date_____

Signature of Patient_____Date_____