CONSENT FOR INSERTION OF A MANDIBULAR STAPLE IMPLANT

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your condition and the recommended treatment so that you may make an informed decision whether to undergo the procedure after you know the risks and complications involved. This disclosure is not meant to alarm you; but is an effort to properly inform you so that you may give or withhold your consent.

_____1. I hereby authorize Dr._____and staf f to treat the condition described as:_____

_____

_____2. The procedure recommended to treat the condition has been explained to me and I understand the nature of the procedure to be:_____

_____

_____3. I have been informed of possible alternative methods of treatment (if any) including:

_____

_____4. I understand incisions will be made both inside and outside of my mouth for the purpose of placing a metal implant in my jaw to serve as an anchor to stabilize a denture.

_____5. No assurances have been given that this implant will last for a specific time or that a perfect result can be guaranteed. It has been explained that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If not, the implant may fail.

_____6. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this treatment such risks include (but are not limited to):

_____ A. Post-operative discomfort and swelling that may require several days of at home recuperation, as well as chewing and diet restrictions.
_____ B. Prolonged or heavy bleeding, formation of a hematoma (blood clot) at the surgery site or in the floor of the mouth, and possible bruising of the chin and lips, any of which may require additional treatment.
_____ C. Post-operative infection that may require additional treatment.
_____ D. Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.

_____ E. Restricted mouth opening for several days or longer, sometimes related to swelling and muscle soreness and sometimes related to stress on the jawjoints (TMJ). Pre-existing TMJ symptoms may be worsened.

_____ F. Fracture of the jaw, especially when an implant is placed in a very thin jaw.

_____ G. Injury to nerve branches serving the lower lip and gums which may result in numbness, pain or tingling of the chin, lip, gums, tongue, or floor of mouth which may persist for several weeks or months and may, in rare instances, be permanent.

_____7. The surgical approach to this implant is by a skin incision underneath the chin, which will leave a slight scar. A good cosmetic result is intended but cannot be guaranteed. If the scar is objectionable, later revision surgery may be desirable.

_____8. I understand that any of the above treatment complications may necessitate additional medical, surgical or dental treatment, may necessitate wiring of the jaws, and may require an additional period of recuperation at home or in the hospital.

_____9. I have been told that this treatment may not prove successful, that problems may arise during the surgery that will prevent the placement of the staple, and that rejection of the staple is possible which will necessitate its removal. Should the implant require removal, I understand that it may be possible to insert another staple following a suitable period of bone healing.

_____10. I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in the procedure.

_____11. It has been explained to me that during the course of the surgery unforseen conditions may be revealed which will necessitate extension of the original procedure or different procedure from those above. I authorize my doctor to perform such other procedure(s) as are necessary and desirable in the exercise of professional judgment.

_____12. I understand smoking is extremely detrimental to the success of implant surgery. I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery, including the later uncovering procedure, and to make strong efforts to give up smoking entirely.

_____13. **ANESTHESIA**

The anesthetic I have chosen for my surgery is:

❒ Local Anesthesia
❒ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
❒ Local Anesthesia with Oral Premedication
❒ Local Anesthesia with Intravenous Sedation
❒ General Anesthesia

_____14. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

_____15. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**
D. **However,** it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water**.

_____16. No guaranteed or warranted results have been offered or promised. I realize my doctor may discover conditions which may require different surgery from that which was planned and I give my permission for those other procedures that are advisable in the exercise of professional judgment to complete my surgery.

CONSENT

I have had an opportunity to have all my questions answered by my doctor and I certify that I speak, read and write English. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and the anesthesia I have chosen.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date