ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES OF CHESTER COUNTY, LTD

CONSENT FOR TWO STAGE OSSEOINTEGRATED IMPLANT SURGERY DATE: _____

Patient Name	*Account #*

Special Notes:_____
_____
_____

It is important for you to be informed about your condition and the recommended treatment plan so that you, with the assistance of your doctor, make an informed decision as to whether or not to undergo treatment. What you are being asked to sign is a confirmation that you have discussed, with your doctor, the nature of the proposed treatment, the known risks associated with it, possible benefits, and feasible alternative treatment.

PLEASE INTITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

____ 1. This is my consent for Dr. Disque and/or Dr. Gustainis and/or Dr. Trentacosti to perform the following treatment, procedure or surgery. _____

_____

_____

____ 2. I understand that incisions will be made inside my mouth for the purpose of placing one or more tooth root form implant in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure and the type and number of implants to be used. I understand that all restorative treatment will be provided by Dr._____ and that a separate charge will be made for that work. If an abutment is placed by our office an additional fee will be charged.

____3. I understand that following the implant placement it is necessary to allow the tissues to heal for 3 to 6 months before it can be used and that a second procedure may be required to uncover the top of the implant. No guarantee can or has been given that the implant(s) will last for a specific time period. I understand it is important for me to follow the schedule and recommendations made by my doctor to maximize the possibly of implant success.

_____4. I have been informed of possible alternative methods of treatment (if any) including:

_____

_____

_____5. I understand that certain anesthetic risks, which could involve serious bodily injury etc., are inherent in any procedure that requires a general or sedation anesthetic. I consent to the administration of _____ anesthesia.

_____6. Dr. Disque and/or Dr. Gustainis and/or Dr. Trentacosti has explained to me and I understand that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

_____A. Postoperative discomfort and swelling.

_____B. Prolonged or heavy bleeding that may require additional treatment.

_____C. Injury or damage to adjacent teeth or roots of adjacent teeth.

_____D. Postoperative infection that may require additional treatment.

_____E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.

_____F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

_____G. Injury to the nerve branches in the lower jaw resulting in numbness or tingling of the chin, lips, palate, cheek, gums or tongue on the operated side. This may persist for several weeks, months or in rare instances may be permanent. Surgery may result in nerve irritation or atypical facial pain lasting and indefinite length of time.

_____H. Opening into the sinus (a normal chamber above the upper teeth) requiring additional treatment.

_____I. If the sinus is intentionally entered (sinus lift procedure with grafting) there will usually be several weeks of sinusitis symptoms requiring medications and additional recovery time.

_____J. Fracture of the jaw.

_____K. Failure of the implant(s) to fuse to the bone, requiring its removal.

____ L. Other _____

_____

____ 6. It has been explained to me that during the course of the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from those set forth in Paragraph 1 above. I authorize my doctor to perform such procedure as necessary and desirable in the exercise of profession judgment.

____ 7. It has been explained to me, and I understand, that a perfect result is not and can not be guaranteed.

____ 8. I agree to cooperate completely with the recommendations of Dr. Disque and/or Dr. Gustainis and/or Dr.Trentacosti while I am under their care, realizing that my cooperation will help in achieving optimum results.

I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY APPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I SPEAK, READ, AND WRITE ENGLISH.

_____ _____
Patient's (or legal guardian's) signature Date

_____ _____
Witness signature Date

_____ _____
Doctor's signature Date