

Informed Consent

Procedure(s): _____

Area of treatment: _____

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with your doctor. It is important that you fully understand this information, so please read this document thoroughly. Not all these risks may pertain to you. If you have any questions regarding the procedure or this consent form, ask your doctor prior to signing.

RISKS

Known risks of this treatment include, but are not limited to:

- Pain, bleeding, bruising, redness, delayed healing, swelling, and infection at the treatment site and surrounding areas.
- Pain from incomplete numbing of the area and/or tissue necrosis at the injection site.
- Allergic reaction to local anesthetics, other medications, and dental materials given during or after the procedure.
- Discoloration and appearance changes of the gum tissue.
- Damage to teeth, dental appliances, or soft tissue that may result in the need for tooth repair or loss, loose teeth, retention of tooth fragment, bone, or foreign material in the body, cracking or cuts of the mouth or lips, and difficulty in opening or chewing.
- Wound infection, bone infection, dry socket, poor healing, sharp ridges, bone splinters, or opening of the incision.
- Nerve injury, which may occur from the surgical procedure and/or delivery of anesthesia, resulting in permanent or temporary loss of sensation, pain, or altered sensation in the following structures: face, cheeks, lips, chin, teeth, gums, roof of the mouth, and /or tongue, including loss of taste. Such conditions may resolve over time. This may change the appearance of your face or make your tongue weak or numb.
- Damage/stress to the jaw joint and jaw bone.
- Part of the tooth and/or roots may be left intentionally to prevent damage to nerves or other anatomical structures or can be left unintentionally.
- The procedure may fail or need to be repeated.
- Loosening, loss, and rejection of dental materials used in surgery leading to poor outcomes.
- If grafted donor bone, bone substitutes, or donor gums are being used, there is a rare chance of disease transmission from the processed material.
- Inability to place the implants due to the local anatomy, insufficient bone volume, or bone quality that will not support the implant.

- Bone loss around the implant(s) and/or adjacent teeth that can lead to gum recession.
- Aspiration or ingestions of foreign object during the procedure that may lead to hospitalization or additional treatment.
- An opening may occur from the mouth into the nasal or sinus cavities that can be temporary or permanent.
- Unintentional placement of foreign object/material into sinus cavity requiring further treatment from other specialists.
- Unsatisfactory functional and/or cosmetic result.
- For mild sedation/anxiolysis and medications administered during your visit including local anesthetics: nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness, heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death. Some patients may experience impaired cognitive function and physical coordination, inadvertent transition to moderate sedation which can cause temporary amnesia or forgetfulness. It can interfere with your ability to drive, operate machinery, or make important decisions for up to 24 hours. It can cause allergic reactions, respiratory depression (breathing slows down and may stop), low blood pressure, and a slow or irregular heartbeat. Any of these complications may lead to hospitalizations and on rare occasion, death.

PRECAUTION

For patients who have taken or are taking drugs such as **Bisphosphonates, 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 of the jaw or failure of the bone/gums to heal. This may cause failure of the procedure and serious permanent consequences that need further treatment and assistance from an oral surgeon or other specialists. Please advise your doctor if you have taken, are taking, or are planning to take these types of medications before your procedure.

CONTRAINDICATIONS

Smoking, alcohol intake, or uncontrolled diabetes (A1c greater than 7%) may adversely affect the healing process, limiting the resulting success of your procedure.

ALTERNATIVES:

No treatment

LOCAL ANESTHETICS:

Local anesthetics are medications administered to numb the area of operation and decrease discomfort during the procedure. These medications may also be used to constrict blood vessels for bleeding control during your surgery. Anesthetics may cause temporary rapid heart rate. It may cause discomfort during their administration and after, once the numbing effect has dissipated. Please inform your doctor if you have had a reaction to an anesthetic or if you are pregnant, breast feeding or have a medical condition for which anesthetics with epinephrine should be prevented. On rare occasions, patient may experience an allergic reaction to anesthetics.

MINIMAL SEDATION/ANXIOLYSIS:

Mild Sedation is a drug-induced state during which patients respond normally to verbal commands. If your doctor has chosen to prescribe an oral sedative for mild sedation/anxiolysis, please follow the instructions carefully. These medications are prescribed and used to decrease anxiety during a procedure. Patient response to these medications varies. Patients are expected to remain aware and responsive during the procedure. Minor risks of mild sedation include impaired cognitive function and physical coordination, inadvertent transition to moderate sedation which can cause temporary amnesia or forgetfulness and drowsiness. It can interfere with your ability to drive, operate machinery, or make important decisions for up to 24 hours. Medications used for sedation can cause allergic reactions, respiratory depression (breathing slows down and may stop), low blood pressure, and a slow or irregular heartbeat. In rare instances, these complications can cause death.

If I opted for mild sedation/anxiolysis, I acknowledge that I have a responsible adult drive me to and from my dental appointment on the day of the anxiolytic procedure. After taking oral sedative, I am not permitted to drive or operate hazardous machinery for 24 hours. I acknowledge that if a change in the treatment plan is required during the anxiolytics procedure, I authorize the dentist to make necessary changes based on professional judgment and my best interest.

IMPORTANT: This consent form must be carefully reviewed and signed **before taking any prescribed oral sedative medication.** Failure to complete and sign this form prior to medication administration will result in cancellation of your procedure and will be subject to the practice's cancellation fee policy.

Initials_____

CONSENT

By signing below, I attest that I have disclosed all my past and present medical history, recent alcohol or recreational drug consumption, current prescription/non-prescription medications, if I am pregnant or lactating, and all allergies/intolerance to medications. I understand and agree to follow all instructions provided to me by Dr. Melcher and staff before and after the procedure, practice proper oral hygiene, keep all appointments, make return appointments if indicated and if complications arise, and complete the treatment which was indicated for me.

I understand and accept that smoking of any kind and use of tobacco products including chewing and cigars is detrimental to the success of my treatment and I will comply with my doctor's instruction or take full responsibility should poor outcomes or failure of treatment result.

I understand and accept that the doctor cannot guarantee the results of the procedure or the length of time needed to complete my treatment.

Dr. Melcher and/or a staff member has explained this treatment/procedure and what it is for, how this procedure could help me, and also reviewed the associated risks and complications. Alternative treatments that could be done instead were explained to me, and what might happen if I decline this procedure. All of my questions have been answered to my liking. I know that I may refuse or change my mind about having this treatment/procedure. I had sufficient time to read this document, understand the entirety of this consent and above statements, and have had a chance to have all my questions answered.

By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed. I hereby give my consent to have this treatment/procedure.

Patient's name (printed): _____

Patient's signature: _____ Date: _____

Witness name: _____

Witness signature: _____ Date: _____