Andrew P. Cox, D.D.S.
Paul C. Cox, D.D.S.

1011 Cedar
Trenton, MO 64683
(660)359-6889
www.cedardental.biz

Statement of Consent for Surgery:
Osseointegrated Implants

I, _____ hereby authorize and request Andrew P. Cox, D.D.S., and/or Paul C. Cox, D.D.S., to perform the following pre-prosthetic procedures and adjunctive augmentations:

____ Extraction of teeth number(s):_____

____ Place implants on teeth number(s):_____

____ Bone Grafting in ___ arch, ___ quadrant; and ___arch, ___quadrant.

____ Sinus lift:_____

____ Remove implants on teeth number(s):_____

And, in the event of unforeseen circumstances, I consent to the performance of such additional and alternative procedures as in the judgment of the above doctor that may be necessary to restore and/or preserve my overall health including, but not limited to bone grafting and sinus lift.

— 1. **Implant Success.** I understand that for implants to be successful, they must bond directly to the jawbone (called osseointegration). To assist with the osseointegration process, I understand that it is sometimes necessary to place artificial or cadaver bone in conjunction with the implant(s) and that this decision may not be made by the doctor until after surgery begins. It has been explained to me that implants are not 100% successful and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implants or will be removable by me.

— 2. **Treatment.** I understand that the initial surgical procedure involves making an incision in the gums and exposing the underlying jawbone. Holes are then drilled into the bone and the implant(s) are placed into these holes. I do understand that at this time, and upon the doctor's discretion, synthetic or cadaver bone may be placed in the drilled tooth site prior to the placement of the implant. I further understand and agree to sinus lift procedures at this time should the doctor deem it necessary. The gums are then stitched closed and the area allowed to heal for a variable period of time (usually 3-6 months or more). I understand that I will have to

Andrew P. Cox, D.D.S.
Paul C. Cox, D.D.S.

Cox Family Dentistry

1011 Cedar
Trenton, MO 64683
(660)359-6889
www.cedardental.biz

avoid wearing my denture(s) for 1-2 weeks after this first surgery and then use them carefully for several weeks until healing is complete. After the healing period, a second surgical procedure is performed to expose the implants and attach extensions onto them, which will eventually support the restoration(s). Shortly after this second surgery the prosthetic phase of treatment will take place which will involve several appointments.

— 3. **Alternatives to Implants.** I have considered the following alternative(s) to implant treatment:

A. No treatment
B. Construction of conventional complete or partial denture(s)
C. Tooth replacement with conventional bridgework supported by my remaining natural teeth (if possible).

— 4. **Risks of Implant Treatment, Sinus Lifts & Bone Grafting.** I have been informed and I understand that the risks of NO treatment include, but are not limited to; possible movement and drift of existing teeth and structures; periodontal disease which could lead to the loss of teeth if not treated; having no dentition to function with; continuing use of removable partial or complete dentures with associated potential for discomfort and shrinkage of the jawbones which would require periodic relining or remaking of the denture(s).

I understand that surgical risks of receiving implants and in performing sinus lifts and bone grafts include, but are not limited to; infection, bleeding, adverse drug reaction, discomfort, bruising, perforation of the sinus or floor of the nose, damage (transient or permanent) to the nerve that gives feeling to the lower lip which could result in numbness, tingling or other sensations in the lower lip, bone fracture, jaw joint injury, or loss of one or more implants.

I further understand excessive bleeding may be the result of prescription or over the counter blood thinning medications such as aspirin. At this time **I AM_____, AM NOT_____** taking blood thinning medications.

Further, I state **I AM_____, AM NOT_____** taking bisphosphonates such as Fosamax, Actonel, Boniva, Zometa, Didronel or Aredia for any type of bone disorder.

Patients taking bisphosphonates in connection with dental surgeries have a very small (.7/100,000) risk of developing osteonecrosis of the jaw, which is bone death caused by poor blood supply to the area. Risk increases slightly for patients over the age of 65; who have been taking bisphosphonates for more than 3 years; who have pre-existing oral infection or dental disease; who have diabetes mellitus; who have used steroids; and who have had head and neck raditation treatment.

Andrew P. Cox, D.D.S.
Paul C. Cox, D.D.S.

1011 Cedar
Trenton, MO 64683
(660)359-6889
www.cedardental.biz

I understand that prosthodontic risks include, but are not limited to, failure of an implant to osseointegrate (may be immediate or delayed), fracture of the restoration and/or implant components, wear of the restoration requiring remake, compromised esthetic or finctional outcome as a result of implant loss or less than ideal angulation or position of the implant(s).

I understand that my tongue will need to adapt to changes in my teeth, which may affect my speech, until the tongue accommodates the changes.

— 5. **Risks of Smoking.** I understand the harmful effects of smoking and have been advised that I cease smoking prior to surgery in order to prevent the toxic chemical effects on healing tissues. I also understand that it has been recommended that I should discontinue the use of tobacco at least until the final prosthesis is delivered, and it would be better for me to stop using tobacco products completely. This is the biological rationale and any deviation from this could jeopardize the success of my dental implants.

By my signature below, I acknowledge the above information has been read and reviewed with me by a member of the doctor's staff. I further acknowledge I have been given the opportunity to ask questions, have them answered satisfactorily and discuss any concerns of all information received. I verify a copy of this consent has been received by me this date and a signed copy has been retained for my patient file.

_____ _____

Signature Date

_____ _____

Witness Date