Consent to Perform Implant Surgery

Travis C. Wiles, DDS
600 N Main Ave.
Erwin, TN 37650

Section I

Proposed
Treatment:_____
_____
_____

Dr. Travis C. Wiles has explained to me the dental treatment indicated above and answered my questions, to my understanding.

_____ (initial) 1. The nature of my dental condition has been explained to me, including any circumstances which may possibly compromise treatment outcome.
_____
_____
_____

_____ (initial) 2. Alternatives to dental implants have been discussed as proposed treatment options. Potential risks/benefits for each option have been explained.
_____
_____

_____ (initial) 3. I have disclosed all known information to provide my current medical history. Any existing medical conditions which are significant to treatment outcome may require the consultation of my physician before treatment is rendered.
_____
_____
_____
_____

Resting Heart Rate:_____ Pulse Rhythm:_____ Date:_____

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Section II

_____
(initial)

I understand that Dr. Travis C Wiles will take every reasonable precaution to avoid problems and reduce the risks associated with my surgery. I also understand that it is realistic to assess the risks associated with dental implants, just as with any other surgical procedure.
Possible risks associated with my treatment include:

- Pain and/or Discomfort
- Infection
- Rejection of the implant
- Swelling and Bruising
- Bone Loss
- Failure of the implant due to design or chewing forces of permanent dental prosthesis attached to implant, unrelated to implant surgical placement.
- Peri-implant disease (infection and bone loss around implant) if regular, good oral hygiene is not maintained by my home care and periodic recall appointments.
- Paraesthesia—(associated with lower jaw surgeries)--loss of feeling or sensation due to nerve trauma during surgery, or due to post-surgical swelling.
- Sinus complications—(associated with surgeries of upper jaw) Possible infection, delayed healing, and/or irritation.

_____ I have been cautioned about smoking or using other tobacco products, and I
(initial) understand that there is an increased risk for failure or delayed healing. If the implant is lost due to the use of tobacco products, then it will not be replaced, and I forfeit all fees paid for the implant procedure.

_____ No one has made any promises or guarantees to me, or anyone else
(initial) associated with me, concerning the outcome of this treatment.

Therefore, I give my consent to the proposed treatment including all necessary post-operative procedures

(Patient's Name—PRINT)_____
(Patient's Signature)_____Date:_____
Witness:_____
Doctor's Signature_____