Charles J. Burliss
DMD, MScD, PC

IMPLANT CONSENT FORM AND INFORMATION

- I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the surgical placement of an implant into the jawbone.

- Upon comprehensive oral exam Dr. Burliss and I have determined the best course of treatment for my condition is the placement of a dental implant. Dr. Burliss and I have discussed all available opinions prior to this decision.

- I have been informed of possible risks and complications involved with the surgery, drugs and anesthesia. This includes pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur and the exact duration may not be determinable and may be irreversible. Other unforeseen factors may occur as well.

- I understand that if nothing is done, any of the following may occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, shifting of teeth, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint problems, headaches, referred pains to the back of the neck and facial muscles.

- Dr. Burliss has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of dental implants.

- It has been explained that in some instances implants fail and must be removed and may be replaced. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome or results of treatment/surgery can be made. If the implant(s) should fail one year from finalization of the crown(s) placement, Dr. Burliss will replace that (those) components which he had placed at cost.

- I understand that moderate to heavy smoking or drinking of alcohol will effect gum healing and will significantly reduce the success of the implant. I agree to follow Dr. Burliss's home care instructions. I agree to report to Dr. Burliss for all post-operative visits scheduled.

- To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergies, unusual reactions, abnormal bleeding or any other conditions related to my health.

- I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of the implant dentistry provided my identity is not revealed.

PERIODONTICS - IMPLANTOLOGY
LASER PERIODONTICS

29 Stiles Road, Suite 201 • Salem, New Hampshire 03079
(603) 898-1961 • Fax (603) 898-4508
www.PerioNH.com

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- I request and authorize medical/dental services for me including implant and other surgery. I fully understand that during and following the contemplated procedure conditions may become apparent which warrant, in the judgment of Dr. Burliss, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care if it is considered to be in my best interest.

- I certify that I have fully read and understand the scope and content of this consent form.

_____
Patient/Guardian Signature Date

_____
Surgeon/Witness Signature Date

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