



I, (print name) _____, hereby request and authorize Dr. Chahine at Dental Wellness and Health to provide me with oral implants.

The procedure has been fully explained to me, and I understand, that success with implants depends on the cooperation of the patient, and on the individual body response that cannot be accurately determined prior to the placement of implants.

I have been made aware of the following possible complications: improper occlusion, prosthetic and/or material failure, loss of permanent teeth, loss of prosthesis and/or the implant should dental disease develop due to improper home care, loss of the implant and/or prosthesis should systemic disease develop, and wear or breakage of the implant component and or the prosthesis. Other complications may occur that cannot be predicted at this time. Should any of the complications occur, I understand that there may be a need to surgically remove the implant and the use of alternative forms of treatment.

Specific complications related to my care may include: _____

I have been made aware that smoking will jeopardize the integration of the implant and the long term health of the entire restoration complex. The excessive use of alcohol and sugar will have an adverse effect on my body's response, and may therefore affect the success of the implant, as will my cooperation in performing prescribed home care.

I understand that should the implant fail for any of the above reasons, I may require corrective surgery, and/or the modification of the restoration.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the use of the implants. I also understand that temporary restorations are not permanent restorations and that "permanent" restorations may need repair or re-make in the future

I understand that I am to return to the dental office at regular intervals for the purpose of examining the status of the implant and my oral health, and that a reasonable fee will be charged for such visits.

In case of an acute emergency and in the event I cannot reach this office or we have not returned my call in a reasonable amount of time, I should proceed to the nearest emergency room for medical attention.

I acknowledge that no guarantees or assurances have been given by anyone. Alternative treatment plans have been fully explained to me along with possible outcomes and risks.

I have been given ample time to discuss the procedure with the doctor and have had all of my questions and concerns answered to my satisfaction.

I certify that I fully understand all matters as described in this AUTHORIZATION AND CONSENT FOR IMPLANTS.

Patient's Signature (Or Guardian if a Minor)

Doctor's Signature

Witness's Signature

Date