MARIANNE MORELLI, D.M.D.
BROOKFIELD FAMILY DENTISTRY, LLC

IMPLANT CONSENT FORM

1. **Authorization**- I hereby authorize Dr. Marianne Morelli and her assistants (to assist) to insert dental implant(s) and/or mini dental implant(s) in my jaw and/or bone grafts (sterilized human bone) as needed.

2. **Nature and Purpose of the procedure**- The placement of the titanium implant(s) in the jaw will serve as a tooth replacement/anchor to stabilize a crown, bridge or denture. I understand that the crown/bridge/denture is another procedure that will be placed at a later date and these fees are separate from the implant fee. The implant may be covered under your gum for a few months and may not get the restoration until later.

3. **Alternatives to a dental implant**- The alternative treatments include no treatment at all, bridge, partial denture or complete denture depending on your clinical situation.

4. **Risks and Complications**- I have been informed that there are risks and complications that can arise that include but are not limited to:
   - Bruising and/or Discoloration of Gums
   - Fracture of bone or jaw
   - Implant failure
   - Infection
   - Injury to adjacent teeth
   - Pain and/or swelling
   - --Recession of gum causing exposure of the implant
   - -- Requirement of additional procedures
   - -- Scarring of gums
   - -- Sinus penetration
   - Placement of the final restoration may be delayed as a result of healing and/or complications
   - Prolonged or permanent numbness of the lip/ tongue/chin/teeth may occur. The exact duration of which
     may not be determined and may be irreversible

5. **Periodic Checkups**- I understand the periodic cleanings and exams are very important to the success of the implant. Any bite changes or even slight looseness in the crown or implant must be reported immediately as it will ***not*** return to normal and the implant may fail.

6. I understand that if nothing is done, any of the following could occur; bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also

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possible are inflammation of a vein or artery, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

7. My doctor has explained to me that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
8. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.
9. I understand that the use/consumption of alcohol, cigarettes, e-cigarettes, vaping and marijuana will affect gum healing and put the implant at a higher risk for failure. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
10. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until filly recovered from the effects of anesthesia or drugs given for my care.
11. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites; anesthetics, pollens, dust, blood, or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
12. I consent to photography, filming, recording and x-rays or the procedure to be performed for the record keeping of any treatment and advancement of implant dentistry, provided my identity is not revealed.
13. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve any modification in design, materials or care, if it is felt this is for my best interest.

PATIENT PRINT NAME _____

NUMBER & LOCATION OF IMPLANT(S)_____

PATIENT SIGNATURE _____ **DATE** _____

DOCTOR SIGNATURE _____ **DATE**_____

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