PATIENT CONSENT FORM

Please sign at the bottom of this sheet to confirm the following:

I am fully aware of the proposed treatment plan as outlined in the treatment proposal letter which is fully explained to me by the dentist and I hereby give my consent for the implant treatment and any additional treatment or modifications of it, which is to be carried out under a local anaesthetic.

I understand the purpose and the nature of the implant treatment, what is necessary to carry it out, and what is necessary to maintain the implant retained teeth in good health.

I understand that, where the bone is found to be inadequate to receive an implant, it may be necessary to place a bone graft or bone substitute to improve the chance of success.

The dentist has examined my mouth clinically and radiologically.

I am aware of the diagnosis, possible treatment alternatives, the cost estimate, the prognosis, any aesthetic and functional limitations of treatment and expectancy of success, possible complications that may occur, advantages and disadvantages of the proposed treatment.

I understand that, following surgery, it may be necessary for me to take antibiotics to counter infection and I agree to refrain from smoking and alcohol consumption. I have been informed and I understand the importance of good oral hygiene and regular dental check-ups and maintenance visits.

I agree to see my dentist regularly at least every six months for routine examination and periodontal/implant maintenance. I understand that the healing processes, and therefore the success of implant treatment, can vary from one individual to another and no assurances can be given. I also understand that should the implants/bone grafts not heal successfully then it may be necessary to have additional treatment.

I have been informed of the possible risks and complications, including persistent pain, swelling, numbness of the lip, chin, adjacent teeth, tongue, and the possibility of failure of one or more implants. I understand that these complications, though uncommon and usually temporary, may in very rare cases be irreversible. I am also aware that the success rate of dental implant treatment is generally very high, and I understand the main “factors” which can affect the success of implant treatment.

I also understand that the implant procedure or the subsequent treatment may not be completed or carried out completely by my current dentist and therefore I give my consent for his/her mentor/supervisor to complete the treatment if it is felt that this may be in my best interest during treatment.

I have fully answered the Medical History Questionnaire and, to the best of my knowledge, I have disclosed my physical health history accurately. I understand that if I am a smoker, as stated in my Medical History, the implant/graft placed will not be guaranteed.

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

I declare that I have received two copies of this consent form in advance of my operation date together with a copy of the treatment proposal letter and additional patient information letter and I have kept a copy of these documents for my information.

PATIENT NAME	*SIGNATURE*	*DATE*

DENTIST (This section to be completed by the dentist)

I confirm that I have explained both verbally and as described in the treatment plan proposal letter, the procedure or treatment, and such appropriate options as are available to the patient in terms which, in my judgment, are suited to the understanding of the patient.

DENTIST NAME	*SIGNATURE*	*DATE*

ANGEL DENTAL IMPLANT CENTRE
BRENT
92 Chamberlayne Road Brent London NW10 3JL
020 8969 3560 | info@angel-implants-centre.co.uk

ANGEL DENTAL IMPLANT CENTRE
WESTMINSTER
Unit 4 Monck Street Westminster London SW1P 2BQ
0204 525 9995 | info@angel-implants-centre.co.uk

www.angel-implants-centre.co.uk