INFORMED CONSENT FOR IMPLANT AND IMPLANT-RELATED

Name:
Date of Birth:
HC#:

Date:

This is my consent for Dr. Bourget to perform the following procedure(s):

_____

and such other additional or alternative procedures during the course of treatment as may be felt necessary or in my best interests. I consent to the use of local anesthetics, sedation or general anesthesia for the purpose of this treatment. I consent to photographs, filming, recording, and x-rays of the procedure, provided my identity is not revealed.

The nature and the purpose of the procedure(s), the potential risks or complications involved, and possible alternative treatments have all been explained to me. These risks include, but are not limited to:

1. Pain, swelling, bruising
2. Bleeding (may require additional or urgent treatment)
3. Infection (may require additional or urgent treatment)
4. Limited jaw opening, including aggravation of TMJ (jaw joint) pain
5. Injury to adjacent teeth or fillings which may require repair or loss of those teeth
6. Decision to leave a part of a tooth or root in the jaw
7. Permanent injury to nerves of the lower lip, chin, jaw and tongue causing numbness and/or pain
8. Perforation of the sinus in the upper jaw (if procedure in upper jaw being done)
9. Aggravation of existing sinus problems (if grafting in sinus {sinus lift} being done)
10. Unusual or allergic reaction to medications given or prescribed (potentially life threatening)
11. Fracture of the jaw
12. Inability to place the implant at time of surgery
13. Loss of implant (failure to initially heal and failure to maintain over time)
14. Failure of bone graft or graft material to “take”, or premature loss, leading to need for further grafting
15. If getting bone substitutes such as Allogenic Bone, Xenogenic Bone (DBX, Creos, PRP) risk of infectious disease transmission
16. Autogenous grafts, (graft from your lower jaw to donor site) can create persistent pain to harvest site, numbness, tissue damage.
17. Injury to eye (globe) or surroundings (Zygoma Implant)
18. Infection of the eye/cheek (Zygoma Implant)
19. Loss of bone, asymmetry pot Zygoma Implant placement
20. Loss of Implant, loss of soft tissue, need for additional surgery (Zygoma Implant)

- I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. I understand that implant dentistry is not an exact science, and the treatment may achieve a sub-optimal result or even fail for reasons beyond my or the surgeon’s control or ability to predict. I realize that should additional procedures be required, **I may be responsible for their expense**. I agree to cooperate completely with the surgeon and his team, and to follow the post-operative instructions to the best of my ability for my own benefit and safety. I have had the opportunity to ask questions concerning these procedures and all my questions have been answered satisfactorily.

- Dr. Louis Bourget has explained that there is no method to accurately predict the gum and bone healing capability in each patient after the placement of the implant
- I recognize that extensive use of smoking, vaping, alcohol, recreational drugs, or sugar may affect healing and may limit the success of the implant. I agree to follow my doctor's home care instructions and agree to report to my doctor for regular examinations as instructed.

- I understand that my implants, like my teeth **require exams and cleanings, in order to prevent gum disease and bone loss**, and that if I do not go for regular care of my implants and teeth that gingivitis and peri-implantitis may lead to the eventual loss of my implants.

- I understand that failing implants would require surgical removal and may require additional placement of additional implants.

IV SEDATION & GENERAL ANAESTHETIC PATIENTS: I understand I am not to operate any vehicle, hazardous device, sign legal documents, be left unattended or drink alcoholic beverages for at least 24 hours following surgery.
I am aware that a responsible adult must accompany me to and from the office. I know and agree to an appropriate period of fasting prior to the procedure as described in the pre-operative pamphlet or website or described by my surgeon.

If performed at the East Coast MediCentre, this facility is a member of the Canadian Association for Accreditation of Ambulatory Surgery Facilities and as part of the requirements, your chart may be subject to a peer review for quality control by the Canadian Society for Accreditation of Ambulatory Surgery Facilities.

I have reviewed the above procedure(s) and the risks today, have been given the opportunity to have further questions answered, and hereby authorize Dr. Bourget to perform the procedure(s).

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT EXPLANATIONS WERE GIVEN TO ME PRIOR TO TREATMENT.

_____ **Date:**_____

Patient *or* Consenting Adult

Doctor's Signature _____