**Two-Stage Endosteal Osteointegrated Implant Surgery**
**Statement of Consent**

1. I hereby authorize Dr. Dennis L. DeDecker, and any other agents or employees of and such assistants as may be selected by any of them, to perform surgery upon me (or upon the person identified below as the patient, for whom I am empowered to consent), to insert a two-stage endosteal osteointegrated implant in my upper and/or lower jaw.

2. I understand incision(s) will be made inside my mouth for the purpose of placing one or more endosteal metal root form structures in my jaw(s) to serve as an anchor(s) for a missing tooth or teeth or to stabilize a crown, denture or bridge. I acknowledge that Dr. DeDecker has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown, denture or bridge will later be attached to this implant by my own general dentist and the cost for that work is not included in the charge for this procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant must remain covered under the gum tissue for at least three (3) months before it can be used and that a second surgical procedure is required to uncover the top of the implant. I also understand that there will be no refund of the fees in the event of failure. It has also been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed and completed on schedule. If this schedule is not carried out, the implant may fail.

3. I have been informed of the alternatives to the use of an osteointegrated implant, including no treatment at all; construction of a new ridge of my upper and lower jaw by means of vestibuloplasty (plastic surgery on gums), skin and bone grafting or with synthetic materials; and implantation of another type of device. The advantages and disadvantages of each of the above procedures have been explained to me and I choose to proceed with insertion of the osteointegrated implant.

4. I also authorize and direct Dr. DeDecker and his associates or assistants to provide such additional services that he or they may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary laboratory radiological (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion or by other medically accepted route of administration; and the removal of bone, tissue and fluid for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices. If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated, and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed necessary and advisable under the circumstances with the exception of_____ (if none, put “none”). Prior to performing such additional or different procedures, however, I desire that they be discussed with _____ (relationship: _____ ), whom I hereby authorize and designated to give consent to treatment on my behalf whenever possible.

5. I understand that there are risks associated with this procedure and these have been explained to me. They may include, but are not limited to the following: swelling; damage to and possible loss of other teeth, fillings or other dental work; infection or abscess; pain; significant bleeding which may be heavy or prolonged; sinus or nasal problems or infection; poor healing; loss of bone; fracture of the jaw; injury to nerves near the treatment site which may cause pain; numbness or tingling of the lips, chin, face, mouth, teeth and tongue (which is usually temporary but may be permanent); loss of or damage to the ability to taste; stretching of the corners of the mouth with resultant cracking and bruising; accidental opening and infection of the normal sinus cavity located above the upper teeth. Although a good cosmetic result is hoped, it cannot be guaranteed. I understand that any of these treatment complications may necessitate additional medical, dental or surgical recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of this implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period and that a charge will be made for this procedure.

6. I understand that follow-up care is extremely important in the care of my dental implant(s). It is recommended that I see my general dentist at least three to four times per year for routine care of my dental implants. It is also important to visit the oral surgeon, Dr. DeDecker, at least once a year for routine follow-up evaluation and x-rays. THESE FOLLOW-UP VISITS AND X-RAYS ARE NOT INCLUDED IN THE INITIAL FEE AND WILL BE BILLED AS CONTINUED SERVICES.

**CONSENT**

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE PARAGRAPHS 1-6 IN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND ALSO STATE I READ AND WRITE ENGLISH.