ROBERT RAMIREZ, D.D.S.
11671 JOLLYVILLE RD., SUITE 101
AUSTIN, TX 78759
(512)335-8600

PT. NAME: DATE:

INFORMED CONSENT AND REQUEST FOR TREATMENT OSSEOINTEGRATED IMPLANTS

To the Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, dental and diagnostic procedure (s) to be used so that you can make the decision whether or not to undergo the procedure (s) after knowing the risks and hazards involved. This disclosure is not meant to alarm or frighten you, it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure (s).

I (we),________________________________ voluntarily request Dr. Ramirez and such associates, technical assistants, employees and other health care providers as may be selected by Dr. Ramirez to place and restore missing natural teeth using osseointegrated implants.

**Patient is to initial each paragraph after reading on the line provided to the left of the number.

___1. I understand and have been informed about the purpose and the nature of the osseointegrated implants.

___2. Dr. Ramirez has carefully examined my mouth. Alternatives to this treatment have been explained. These alternatives typically include **fixed bridge, removable denture or option for no treatment.** I have tried or considered these alternatives, but I request and choose an implant to secure and replace missing teeth.

___3. I understand that if my oral/maxillofacial condition persists without treatment, my present condition will probably worsen in time, and the risk to my health may include, but are not limited to: pain, infection, bone loss, gum and tissue inflammation, sensitivity, looseness of teeth, periodontal (gum) disease, dental caries (decay), malocclusion (bad bite), fracture of the jaw, loss of additional teeth, temporomandibular disorders, headaches, referred pain to the neck and facial muscles and tired muscles during and after chewing.

___4. I understand that incision (s) will be made inside my mouth for the purpose of placing one or more titanium fixtures into my jaw (s) to serve as anchor (s) for a missing tooth or teeth or to stabilize a crown (cap), denture, or bridge. I acknowledge that Dr.

Ramirez has explained the procedure, including the number and location of the incisions to be made. I understand that the crown (cap), denture, or bridge will later be attached to this implant by Dr. ______________________________. I understand that this implant should last for many years, but that no guarantee that it will be a specific period of time can be or has been given.

___5. I authorize and direct Dr. Ramirez and his assistants to provide such additional services as he may deem necessary, including but not limited to, the administration of anesthetic agents; the performance of necessary laboratory, radiological (x-ray), CT scan, 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 fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices.

___6. I have been informed and I understand that there is no method to accurately predict my gum, tissue, and bone healing capabilities prior to the placement of the implant (s).

___7. No guarantee or assurance has been given to me that the proposed treatment will cure my condition and/or be successful to my complete satisfaction.

___8. I understand that there will be no refund of fees in the event of failure.

___9. I understand that inadequate oral hygiene, **excessive smoking**, alcohol, or compromised systemic conditions may affect tissue and bone healing and may limit the success of the implant (s).

___10. I have had the opportunity to fully and accurately inform Dr. Ramirez of my past medical health and oral health history, and have done so.

___11. It has been explained to me that there are risks and hazards in continuing my present condition without treatment, there are risks related to the performance of general and local anesthesia; the surgical, and restorative procedures planned for me; including those required in the event of failure of the implant. Such operative risks include but are not limited to: postoperative discomfort; pain and swelling that may necessitate further treatment and recuperation; damage to and possible loss of other teeth, fillings and dental work; infection or abscess; significant bleeding which may be 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); paralyses, loss of or damage to the ability of 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; restricted mouth opening for several days or weeks; damage to the temporomandibular joint or its associated structures; or even death.

___12. Although a good cosmetic result is hoped, it is not guaranteed. I understand that any of these treatment complications may necessitate additional medical, dental, or