**Implant Patient Information and Consent Form**

1. I have been informed and I understand the purpose and the nature of the implant and/or graft surgery procedure. I understand what is necessary to accomplish the placement of the implant and/or graft in the bone. I have been told about graft materials and consent to their use. I understand that Dr. Kim uses grafting materials from the bovine and human sources.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained.
3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, and discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, and nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
6. 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 assurances as to the outcome of treatment or surgery can be made.
7. I understand that extensive smoking, alcohol or sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. 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 recovered from the effects of the anesthesia or drugs given for my care (not necessary if using only local anesthetics).
9. 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, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health. I have informed the doctor of any and all medications currently taken, including aspirin, herbal remedies, and over the counter medication.
10. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
11. 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 comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Signature of Doctor: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian (if Patient is a Minor): _____

Relationship to Patient: _____