

**IMPLANT SURGERY
PATIENT INFORMATION AND CONSENT FORM**

Patient: _____ Date: _____ Area(s): _____

1. I authorize Dr. Liu to provide implant surgery to replace my missing tooth or teeth as we have previously discussed during the evaluations already performed and which have been explained to me by Dr. Liu and his staff.
2. I also authorize and direct Dr. Liu and his staff to provide services as he may deem reasonable and necessary during the course of the surgery, including but not limited to the administration of anaesthetic agents, the performance of necessary laboratory, radiological and other diagnostic procedures, the administration of medications.
3. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from the current treatment plan, I authorize Dr. Liu to do whatever he deems necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure.
4. The risks, benefits, and alternatives to implant treatment have been explained to me. I understand what is necessary to accomplish the placement of the implant in the bone. I have been informed and understand that there are complications of the surgery, drugs and/or anaesthesia. Possible complications include infection, numbness of the lip, tongue, chin, cheek, or teeth may occur, the exact duration of which cannot be determined and may be irreversible. A communication with the sinus may be encountered when placing an upper jaw implant. Also possible are injury to teeth (if present), bone fractures, delayed healing, and allergic reactions to prescribed medications.
5. Dr. Liu has explained that there is no method to accurately predict, or evaluate the healing capabilities of my gum and bone. I do understand that the success of the implant can be affected by: smoking, alcohol consumption, diet, habitual clenching and grinding of my teeth, and inadequate daily oral hygiene. I agree to report to Dr. Liu for periodic examination and preventive treatment, as prescribed. The most current surgical procedures and materials will be used to help accomplish the most predictable result possible. However, it has been explained that in some patients, implants may fail and must be removed. If Dr. Liu deems removal of the implant necessary, it will be done at no fee during the first year, after that, I understand that a reasonable fee will be charged to cover time and costs.
6. I agree to follow the instructions for post-operative care as give to me by Dr. Liu and his staff.
7. I understand that if nothing is done to correct my dental condition further loss of bone may occur as well as shifting of teeth with bite changes. This may result in an inability to place implants at a later date.
8. 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, anaesthetic, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions relating to my health or any problems experienced with any prior medical, dental or other health care and treatment. If I am currently in treatment for any health problems, I certify that I have discussed the proposed implant procedure with my health care provider and have received his or her consent to undergo this implant procedure.

Please do not hesitate to call Dr. Liu prior to your implant appointment should you have any questions or concerns.

Signature of Dr. Liu

Date

Signature of Patient

Date