

EVERGREEN FAMILY DENTISTRY, P.C.

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INFORMATION AND CONSENT FOR IMPLANT PATIENT-PROSTHETIC

1. I the undersigned, _____, hereby authorize and request **Dr. Troy Fox of Evergreen Family Dentistry, P.C.** to construct a dental prosthesis for use with my surgical implant as indicated by the diagnostic studies and/or evaluations already performed.
2. I have discussed with the implant surgeon and/or **Dr. Fox** the risks associated with the surgical implant and have consented to that procedure.
3. Alternatives to implant surgery and the implant prosthesis have been explained to me, including their risks. I have tried or considered these alternative treatment methods and their risks, but I desire an implant and an implant prosthesis to secure and/or replace my missing teeth.
4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant prosthesis and the associated treatment and procedures. I am aware that the implant surgery and/or prosthesis may fail, which may require corrective surgery or the removal of the prosthesis or implant with possible surgery associated with the implant removal.
5. As with any dental prosthesis, there are possible complications of which I should be aware. These include, but are not limited to the following: the presenting conditions may result in compromised bridge work or compromised occlusion requiring additional care and treatment; risk of prosthetic and/or material failure; loss of permanent teeth; allergic reactions to metals; loss of the prosthesis and/or implant if dental disease develops due to improper home care or other reasons; loss of the implant and/or prosthesis if systemic disease develops; and wear or breakage of the implant components and/or prosthesis. The development of any of these aforementioned risks may result in the need for surgical removal of the implant and the use of alternative forms of treatment. I have been advised that bone grafting and/or guided tissue regeneration may be necessary to correct unforeseen problems that might arise with the implant/crown.
6. I have been advised that the use of tobacco or alcohol may affect the implant and the prosthesis and may limit the success of this treatment. I agree that I will follow my dentist's instructions for home care, oral hygiene and agree to follow my dentist's instructions for professional dental cleaning, follow-up care and treatment once the prosthesis has been placed.
7. I certify that I have read, have had explained to me, and fully understand the foregoing consent to implant prosthesis and that it is my intention to have the foregoing prosthesis constructed as stated. I have been advised that information concerning the longevity of the particular implant and the prosthesis to be used may not be available. However, I have discussed this as well as the nature of the implant product to be used with my doctor and I consent to the procedure knowing its risks and limitations.

Signature: _____
(patient, or parent/guardian if minor)

Date: _____

Doctor: _____

Date: _____