

***STATEMENT OF CONSENT FOR TWO-STAGE ENDOSTEAL  
OSTEOINTEGRATED IMPLANTS***

      1. I hereby authorize Dr. Fagan to perform surgery upon me and 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 anchor(s) for a missing tooth or teeth or to stabilize a denture or a bridge. I acknowledge that Dr. Fagan has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant by my general dentist and the cost for that work is not included in the fee for this procedure. I have been informed that the implant must remain covered under the gum tissue for at least three-four months before it can be used and that a second surgical procedure is required to uncover the top of the implant.

      3. I authorize and direct Dr. Fagan to provide such additional services as he may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary laboratory, radiological and other diagnostic procedures, the administration of medication, and the removal of bone, tissue for diagnostic and therapeutic purposes. 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 in my best interests.

      4. 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, swelling; damage to and possible loss of other teeth, fillings or other dental work; infection or abscess; pain; bleeding; 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 discomfort, 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 my ability to taste. Although a good cosmetic result is expected, it cannot be guaranteed. I also understand that any of these treatment complications may necessitate 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, or another replacement implant may not be necessary for success of the treatment.

If you are planning to be given Oral Sedation or IV Conscious Sedation, **YOU MUST HAVE A RESPONSIBLE ADULT DROP YOU OFF AND DRIVE YOU HOME.** Please have your driver drop you off and pick you up **IN OUR SUITE. NO TAXI'S ARE PERMITTED AND DRIVING IS PROHIBITED FOR THE REMAINDER OF YOUR PROCEDURE DAY.**

**I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE EXPLANATION AND WORDS WITHIN THE ABOVE CONSENT FOR THE SURGICAL PROCEDURE(S). I ALSO ACKNOWLEDGE THAT I CAN READ, WRITE, AND UNDERSTAND THE ENGLISH LANGUAGE.**

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**Patient** **DATE**

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**Surgeon** **DATE**

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**Witness** **DATE**