

Oral & Maxillofacial Surgeons of Houston

R. Kent Stobaugh, D.D.S.

Paul S. Metz, D.D.S., M.D.

Shelley Seidel, D.D.S., M.D.

IMPLANT INFORMATION & CONSENT

1. I have been informed and understand the purpose and nature of the planned implant procedure. I understand the procedures necessary to accomplish placement of the implant under the gum and in the bone.
2. My doctor, R. Kent Stobaugh, Paul S. Metz, and/or Shelley L. Seidel has carefully examined my mouth and has explained alternatives to this treatment. I have tried or considered these methods, but I desire implant(s) to help secure the replaced missing teeth.
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; if so, the exact duration may not be determinable and may be irreversible. Additional possibilities are: inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and/or tired muscles when chewing.
5. Dr. Stobaugh, Dr. Metz, and/or Dr. Seidel has explained that there is no method to accurately predict the gum and/or bone healing capabilities in each individual patient following the placement of the implant(s).
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 and no guarantees or assurances as to the outcome, results of treatment, or surgery can be made.
7. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow Dr. Stobaugh, Dr. Metz, or Dr. Seidel's postoperative instructions and will 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 fully recovered from the effects of the anesthesia or drugs given to me for my care.
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, pollens, dust; any blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.
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/or 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 my comprehensive treatment. I also approve of any modification in design, materials, or care, if it is felt this is in my best interest.

Doctor's Signature

Patient's Signature

*If the patient is unable to sign or is a minor
(signature of parent or legal guardian)

Witness

Date