OLIVER
DENTAL IMPLANTS
The Confident Solution.

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CONSENT FOR TREATMENT

Initial all boxes that apply

I authorize Dr. W. Laurence Oliver, D.D.S. and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) prescribed. I understand my dental condition and have discussed several treatment options with Dr. W. Laurence Oliver. I have been given a printed copy of the procedure or treatment details. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life –saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand my doctor cannot promise everything will be perfect. I have read and understand the above and give my consent for treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify I speak, read and write English. All of my questions have been answered before signing this form.

☐ CONSENT FOR NITROUS OXIDE ANALGESIA ("LAUGHING GAS") $75.00

You will always be given local anesthesia. LOCAL ANESTHESIA will provide a numb feeling in the area being operated on and only pressure will be felt during surgery. You will be awake and aware of the surgery, but there should be no pain or significant discomfort.

1. Have a light meal a few hours prior to the procedure.
2. For more extensive procedures, you may wish to have someone drive you home.
3. Plan to rest for a few hours after the procedure.

You may choose to add NITROUS OXIDE ANALGESIA as a *supplement* to local anesthesia.
Use of nitrous oxide requires we obtain your consent.

NITROUS OXIDE is also known as "laughing gas". You will be relaxed and somewhat less aware of your surroundings, as well as less responsive to minor discomfort, and you may or may not recall much of the procedure. Nitrous oxide is breathed through a nasal mask and, after a state of relaxation is reached, local anesthesia is administered.

Nitrous oxide has few lasting effects, and you usually may drive safely after a fairly brief recovery time. However, for safety precautions, its use does require some preparation on your part. Thus, it is important you read and understand the information below and you prepare by following the instructions carefully. If you are unclear about anything, please ask your doctor.

1. Recovery time from nitrous oxide is usually very short, but may be prolonged, requiring you to remain in the office for some time after surgery. Rarely, you may be unable to drive home alone. Thus, it is best to arrange for a responsible friend or family member to be "on call" for such a possibility.
2. Although not usually required, it may be best to have a responsible adult accompany you to drive you home.
3. You may have a light meal a few hours prior to surgery.
4. Plan to rest for the remainder of the day.

I understand the use of nitrous oxide, although usually safe and without lasting consequences, may affect me differently. I am prepared to deal with any undesirable side effects of nitrous oxide and understand those possibilities listed above, as well as others not considered, may occur. I agree to the use of Nitrous Oxide analgesia ("Laughing Gas") to supplement the local anesthesia planned for my procedure.

☐ CONSENT FOR EXTRACTION OF TEETH

***If you have any questions, please ask your doctor BEFORE signing.**

You have the right to be informed about your diagnosis and planned surgery so you can decide whether to have a procedure or not after knowing the risks and benefits.

Taking teeth out is a permanent process. Whether the procedure is easy or difficult, it is still a surgical procedure. All surgeries have some risks. They include, but are not limited to, the following:

1. Swelling, bruising and pain;
2. Stretching of the corners of the mouth that may lead to cracking or bruising;
3. Possible infection that might need more treatment;
4. Dry socket – jaw pain beginning a few days after surgery, usually needing additional care;
5. Possible damage to other teeth close to the ones being taken out, more often those with large fillings or caps;
6. Numbness, pain or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away but, in some cases, it may be permanent.
7. Trismus – you can only open your mouth a little. This is most common after wisdom teeth are taken out. Sometimes it happens because of joint problems (TMJ), mainly when TMJ disease is already there.
8. Bleeding – oozing can often happen for several hours, but a lot of bleeding is not common.
9. Sharp ridges or bone splinters may form later at the edge of the hole where the tooth was taken out. These may need another surgery to smooth or remove.
10. Sometimes tooth roots may be left in to avoid harming important things such as nerves or a sinus (a hollow place above your upper back teeth).
11. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment.
12. It is very rare that the jaw will break, but it is possible in cases where the teeth are buried very deep in their sockets.

CONSENT FOR ANESTHESIA:

***Please INITIAL beside option you choose:**

☐ **LOCAL ANESTHESIA: (Novocaine, Lidocaine, etc.)** A shot is given to block pain in the area to be worked on.

☐ **ORAL PREMEDICATION WITH LOCAL ANESTHESIA:** A pill is taken for relaxation prior to giving local anesthesia.
If I have Oral Sedation, I agree not to drive myself and to have a responsible adult stay with me once of have taken the oral medication until I am recovered from my medications. I understand that during this time I should not drive, operate machinery or devices, or make important decisions such as signing documents, using my cell phone or email etc. (Medication begins 1 hour before surgery)

☐ **INTRAVENOUS SEDATION WITH LOCAL ANESTHESIA:** Makes you less aware of the procedure by making you calmer, sleepy, and less able to remember the procedure.

If I have IV Sedation, I understand this will require a Dental Anesthesiologist to be present and ***additional charges will apply***. I confirm that **I HAVE NOT HAD ANYTHING TO EAT OR DRINK (INCLUDING WATER) FOR SIX (6) HOURS PRIOR TO SURGERY. I HAVE AN EMPTY STOMACH. TO DO OTHERWISE MAY BE LIFE-THREATENING!** I agree not to drive myself home and to have a responsible adult stay with me until I am recovered from my medications. I understand that during this time I should not drive, operate machinery or devices, or make important decisions such as signing documents, etc.

Whichever technique you choose, giving any medication involves certain risks. These include:

1. Nausea and vomiting
2. An allergic or unexpected reaction. If any allergic reaction is severe, it might cause more serious breathing or heart problems which may need treatment.

In addition, there may be:

1. Pain, swelling or infection of the vein area where the anesthesia or sedation was given
2. Injury to nerves or blood vessels in the vein area
3. Confusion, or a longer period of sleepiness after surgery
4. Heart or breathing responses which may lead to heart attack, stroke or death

Fortunately, these complications and side effects are not common. All forms of Anesthesia are generally very safe, comfortable and easy to deal with. If you have any questions, PLEASE ASK.

☐ CONSENT FOR DENTAL IMPLANT SURGERY AND/OR BONE GRAFTING (One Stage, Two Stage, Immediate Load and Temporary)

***If you have any questions, please ask your doctor BEFORE signing.**

INFORMATION AND CONSENT FORM FOR THE IMPLANT PATIENT

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
3. I have been further informed of the possible risks 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, injury to the 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 the necessity of extraction. Also possible are temporomandibular jaw joint (TMJ) 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. 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 assurance as to the outcome of results of treatment or surgery can be made.
6. I understand that excessive 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.
7. 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 for my care.
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, anesthetic, pollens, dust, blood or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. 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.
10. 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, material, or core, if it is felt this is for my best interest.
11. **SMOKING:** My doctor has explained that tobacco use can be a risk factor for periodontal diseases, which is the main cause of tooth loss in adults. Smoking negatively affects blood flow to the bone and tissues surrounding the gums and teeth, which impairs bone healing. Risks of implant failure are greater due to smoking. I understand that there will be an additional fee for replacement of an implant if failure were to occur.

☐ ***I have read and understand the above risks for implant failure due to smoking***

CONSENT

My signature below signifies all questions regarding this consent have been answered to my satisfaction, and I fully understand the risks involved with the proposed procedures and anesthetic. I certify I read, write and understand English. I hereby give my consent for the planned treatment and/or surgery.

Print Patient's Name or Legal Guardian - Relationship Signature Date