3 on 6™ PROCEDURE PATIENT CONSENT FORM

Patient's Name: _____ Date: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision, and isn't meant to alarm me.

3 on 6™ Procedure

My doctor examined my mouth and has recommended the 3 on 6™ treatment to replacing my missing teeth. Alternative treatments and their associated risks and benefits have been explained to me including doing nothing. I have had all questions answered my satisfaction. I understand that these alternative forms of treatments may include periodontal, endodontic, orthodontic, and/or general dental care. Having been advised of and considering these options, knowing of these alternative forms of treatment to preserve my teeth, I have had sufficient time to consider alternative forms of treatment and elected to have any remaining teeth extracted for the 3 on 6™ procedure. I also understand that I am welcome to seek and obtain a second opinion before consenting to the procedure. I understand that no guarantees can be or have been made to me about the success of this surgical procedure. I agree to cooperate with my doctor's recommendations and advice prior to and following this procedure knowing that not doing so may result in the failure of my implants and/or bridge(s).

I have been informed of the possible risks and complications involved with this procedure including pain, swelling post-operative infection, bleeding, sinus infection and discoloration. Numbness of the lips, chin, tongue or cheek may occur. The exact duration may not be determinable and in rare cases may be painful and/or irreversible.

Also possible are vein inflammation, bone fractures, penetration of the sinus requiring corrective treatment, delayed healing, vertigo, allergic reactions all of which may require corrective treatment, surgery or possible loss of my implants. In addition to risks associated with implant healing including failure for osseointegration, infection or difficulty with gum tissue healing, or unforeseen complications that aren't listed here. Zygomatic Implants, if prescribed, can result in temporary or permanent injury to the sinuses or eye socket with changes in vision (in rare cases blindness) and/or the need for additional surgery or specialist care. In addition, while bleeding is typically minimal during this procedure variations in anatomy can result in significant bleeding which may require additional intervention. The risks include facial nerve injury which may be permanent and painful, because these implants are placed in the area of your upper cheek(s) there may be a slight alteration in appearance and in rare cases scarring that may require corrective treatment. These complications are rare and all precautions will be taken to avoid injury. However, in any surgery unforeseen complications can occur which may require referral to specialist or medical professional. I have also been advised that the implant is a foreign body and may be rejected or poorly tolerated by my bone or surrounding tissues. If this should occur the implant may need to be removed. I also have been advised and have considered that in the event of failure of my implants the treatment option is dentures.

My doctor has explained to me that there is no certain method of predicting my bone or tissue healing capabilities following the placement of the implants and prosthesis. I agree to follow my doctor's post-operative instructions and to immediately notify him/her of any problems that may develop. I understand that, in rare cases, my implants may not accept immediate placement of my bridge. In such a case, I understand that I will be provided with a denture until healing.

I understand that use of any tobacco products or excessive alcohol consumption, may affect gum healing and reduce the success rate of the procedure. Therefore, I agree not to use these products and to follow the instructions of my doctor. I understand that certain medical conditions may contribute to the failure of my implants. I have provided a complete medical and dental history to my doctor. I will also advise my doctor of any changes in my medical and dental conditions prior to my surgery. I agree to see my doctor for all recommended follow-up visits including regularly scheduled cleanings, and to follow my doctors at-home maintenance instructions or any warrantees will be voided. I have been informed and understand that failure to maintain excellent home care and regularly scheduled dental cleanings create a significant risk of losing my implants.

I consent to and authorize my doctor to provide these dental services, the 3 on 6™ procedure, for me. I fully understand that during, and following the recommended treatment procedure, surgery and treatment, conditions may become apparent which warrant, in the professional judgment of my doctor, additional or alternative treatment may be necessary, or abandonment of treatment. I also approve any modification in design, materials, and surgical procedures or care if it is determined that such changes are in my best interest.

On occasion, additional donated bone is used to supplement the patient's bone, or to spare an extensive donor site surgical procedure. Use of such bone may involve separate risks including; but not limited to rejection of the donated graft material together with the entire graft and the remote chance of disease transmission from processed bone. I understand that in my grafting procedure, the use of (autogenous, demineralized, etc.) bone may be used.

It has been explained to me and I understand that a perfect result is not, and cannot be guaranteed or warranted.

I have read and understand all of the information contained in the consent for the 3 on 6™ treatment. I acknowledge that all of my questions have been answered to my satisfaction by my doctor and, knowing the risks; I consent to this procedure.

Photographs

I hereby give my consent for photographs and/or videos to be taken of my smile and teeth. I also grant permission to reproduce, print, and/or publish these images for use in articles, lectures, or advertisements. I understand that some of these images may be used by laboratories for fabrication of bridges and these images will become part of my dental record. I do not expect compensation, financial or otherwise for the use of these images.

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, all blanks were filled in prior to my initialing and signing this form and that all questions were answered to my satisfaction.

_____ _____

Patient's (or Legal Guardian's) Signature Date