MARK NICOLUCCI DDS, MS, FRCD(C)
MURRAY L ARLIN DDS, DIP PERIO
PERIODONTICS & IMPLANT DENTISTRY

Consent for Dental Surgery

Please ask for clarification on anything you do not fully understand.

Suggested Treatment
I have been recommended the following procedures:

_____

_____

The above procedures have been described to me and I understand what they involve. ____

Alternatives to these procedures have been explained to me. ____

For grafting procedures, I understand that the source of the graft may be any of the following: my own body, a human donor, an animal donor, or a synthetic product. ____

I understand there are risks involved with any surgical procedure and I can expect discomfort afterwards. Bruising, swelling, bleeding, tooth sensitivity and gum shrinkage may also occur. ____

I understand there are also many other complications that, although very rare, can occur. These include, but are not limited to: infection, spread of an infection to other areas, damage to teeth, the bone around those teeth or the gum covering them, nerve damage resulting in an altered or painful sensation, fracture of the jaw bones, damage to the jaw joint or jaw muscles, displacement of an object into another part of the body, allergic or sensitivity reactions, nausea and many other complications. ____

I am aware that during surgery, unforeseen conditions may be discovered which would call for a modification to my recommended treatment. ____

I understand that no guarantee or assurance has been given to me that the proposed surgery will be successful. Although it is anticipated and usual for success, the outcome cannot be predicted with certainty as great variation occurs from patient to patient, despite the best of care. We will re-attempt failed treatment and we offer a lifetime warranty on any implant we place, however, this is not a refund policy. This is only valid if our care instructions are followed and you receive regular professional maintenance. ____

I understand that additional procedures may be required at additional costs. ____

I consent to the use of photographs, radiographs, and other forms of record of my oral structures for the purposes of medical discussion and anonymous use in lectures or publications. ____

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT NAME

_____ _____
DOCTOR SIGNATURE* DATE
*only to be signed after verbally confirming patient has read and understands this form