GARDEN STATE
ORAL SURGERY GROUP
gardenstateos.com

CONSENT FOR OSSEOINTEGRATED IMPLANT SURGERY

This is consent for a dentist employed by **Garden State Oral Surgery Group, Bayonne Oral Surgery, or Oral & Maxillofacial Surgery Institute** to place osseointegrated **Straumann, LifeCore, Blue Sky Bio, Calcitek, Paragon, Branemark, Steri-Oss, 3-1, or Other** _____ dental implants into my jawbone or bones for the purpose of giving support to either fixed or removable replacement teeth. It has been explained to me that there are alternative methods to treat my condition, but I desire to have this type of treatment. I understand that this type of tooth replacement requires a two-stage surgical procedure and then a prosthetic phase. A period of between four to six months is needed for the proper healing of the implant. I understand that the

prosthetic phase, including the placement of abutments, will be the responsibility of the restorative dentist, and that there will be a separate fee from the restorative dentist. I understand that the quality of bone, and therefore, the predictability of the success cannot be determined until an attempt is made to prepare the bone for implant placement. The final evaluation of success will not take place until the crown, bridge or denture has been in place for one year.

I also agree to the use of local. IV sedation and/or general anesthesia depending on the judgment of the dentist(s) involved in my care. I have been informed and understand that occasionally there are complications from the surgery, drugs, and/or anesthesia. These complications include but are not inclusive of failure to osseointegrate, pain, infection, bleeding, swelling, discoloration of the skin, numbness and tingling of the lips, tongue, chin, gums, cheeks, and teeth which may persist for days, weeks, months or in some instances permanently. There may be injury to adjacent teeth and/or tissues, referred pain to the ears, neck, and head, bone fractures, sinus complications, and nasal antral fistula or openings, which may require further treatment. There may be nausea, vomiting, allergic reactions, and/or death from the anesthesia. At the injection site, there can be pain, bruising, numbness, and/or inflammation of the vein. It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitate an extension of the original procedure or a different procedure from what was planned. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such procedures that are necessary and desirable in the exercise of professional judgment.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination; thus, I was advised not to operate any vehicle or hazardous device for at least the balance of the present day or until fully recovered from the effects of the medications, drugs, anesthetics, and prescriptions that may have been given for my care in the office or for at home.

I acknowledge the receipt of and understand the post-operative instructions and have been given an appointment to return. I understand that a home care program will be explained to me and that a yearly follow-up including x-rays are necessary for maintenance and to determine the health of the implant and prosthetics. 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, and to report to my doctor for regular examinations as instructed.

The surgery has been explained to me and I understand there is no warranty or guarantee as to the result and/or cure from surgery. 1 understand that I can ask for a full recital of all possible risks attendant to phases of my care by just asking. I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and that I understand its contents. I have sufficient information to give This informed consent.

I authorize, assign, and direct payment of insurance benefits to the office of Bayonne Oral Surgery, PC for moneys due on my bill, which relates to services rendered. I assign to the above dental office the right to prosecute claim(s) against the insurance carrier who affords benefits, and I agree to fully cooperate with this dental provider's efforts to prosecute a claim against the insurance carrier, if there is no timely payment of the claim.

I acknowledge full financial responsibility for services rendered by an employee of Bayonne Oral Surgery, PC I understand that if rny insurance does not pay the fees I incur, I will be fully responsible for them. I agree to pay all reasonable attorney fees and collection costs in the event of default of this payment agreement.

_____ _____

Signature Date

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