OBEID DENTAL IMPLANT TREATMENT CONSENT

Placement of Dental Implants is an advanced procedure. The benefits and risks of dental implants have been explained to me. Additional referral for consultation for this treatment has been offered. I understand that implants are placed into the bone. I further understand that implant treatment is complex and includes the need for proper prosthetic restoration. I also understand that the placement of the implant device and associated risks are separate from the restoration of the implant.

I understand the number and location of implant devices will depend on the availability of adequate bone to support the implant and the number of teeth that need to be replaced. I accept that if during the procedure it is determined that additional procedures be provided to increase the chances of optimal implant integration that may include additional implants, bone grafting, use of biological membrane, deferring temporarily or permanently the placement of planned implants be at the sole discretion if the attending dentist. There may be involvement of the sinus cavities when the implants are placed in the upper jaw. Alternative treatments have been explained to me as well as the option of doing nothing. I understand the risks of no treatment may include, but are not limited to: loss of bone and gum tissues; jaw joint problems; headaches and referred pain; sensitivity; inflammation and infection.

_____ **I understand and accept the treatment recommended for me by my attending dentist.** No guarantees have been made or implied. I also understand that implant supported prostheses require continuing professional monitoring, may require additional treatment in the future, and success is dependent upon home care. I realize implants may become loose and need to be removed or replaced.

_____ **I decline the above option and elect to proceed with a compromised treatment plan.** I understand that consequences of my decision not to have treatment may be, but are not limited to; loss of bone and gum tissues; jaw joint problems; headaches and referred pain; sensitivity; inflammation and infection. I also understand that I will be provided with other hygiene visits to review treatment options.

Treatment risks/unwanted consequences of the proposed implant treatment my be (but are not limited to):

- Reaction to medications/anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, face, tongue and gums
- Damage to nearby teeth and restorations
- Post-Treatment Swelling
- Bruising, bleeding or infection
- Sensitivity, pain
- Poor aesthetic result (involving appearance)
- Failure of implant integration
- Sinus infections/complications

I accept the fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. I acknowledge that restoration and its associated fees are separate from implant placement fees. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have third party benefits. I understand that third party benefits may be different than discussed, as they are not under control of this office.

I have been offered a copy of this consent form for my records. All of my questions have been answered and I understand that should I have additional questions or any concern regarding post-operative signs or symptoms, I will immediately call Obeid Dental at 1-301-652-9505 for a phone consultation or follow-up visit. I also acknowledge that should the office be closed, I will contact the after hours attending dentist with the phone number provided on the Obeid Dental voice mail.

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Patient Signature (or Legal Guardian If applicable), Printed Name Date

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Obeid Dental Team Member Date