Harmony Dental Arts
Informed Consent for Dental Implants

I have been informed and understand the purpose and nature of the implant surgical procedure. I understand what is needed to place the dental implant. All of my questions have been answered. Dr. Sokolina has carefully examined my mouth. Alternatives to this treatment have been explained including doing nothing at all. I have tried or considered these methods. I desire an implant to help secure artificial teeth.

I have been informed of the risks and possible complications 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 teeth present, bone fracture, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

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 necessity of extraction. Also possible are jaw joint problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

It has been explained to me that in some instances implants fail and must be removed. I have been informed and understand 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. Dr. Sokolina has explained to me that there is no method to accurately predict the gum and the bone healing capacities following the placement of the implant(s).

I agree to the type of anesthesia, depending on the choice of Dr. Sokolina. I agree not to operate any motor vehicle or hazardous device for at least 24 hours or until the fully recovered effects of the anesthesia or drugs have been given for my care.

To my knowledge I have given an accurate report of my physical and mental health also reported any prior allergic or unusual reactions to drugs, food, insects bites, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding o conditions related to my health.

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.

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 Dr. Sokolina, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve modifications in design material, or care, if it is felt this is for my best interest.

I understand that regular check ups and cleanings of the dental implants are need and they on average vary from three to six month intervals. In my own words I consent that this is what Dr. Sokolina and team plan on doing for me.

By signing electronically you give Dr. Sokolina permission to proceed with your Dental Implant Procedure. (A copy will be given to you for your records).