Consent for Dental Implant Therapy
(Including Surgery and Restorative Phases)

I herby authorize Dr. H. Kupeyan to perform surgery upon me, to insert endosteal Osseointegrated implant(s) in my upper/lower jaw. This may require one or two surgeries depending on treatment goals.

I understand incisions(s) will be made inside my mouth for the purpose of placing one or more endosteal metal root form structures in my jaw(s) to serve as anchor(s) for missing tooth or teeth or to stabilize a crown (cap), denture or bridge. I acknowledge that Dr. H. Kupeyan has explained the procedure, including the planned number and location of the implants(s) to be placed, in detail.

I also understand that this implant should last for many years, but there is no guarantee that it will last for any specific period of time, if done as a conventional procedure. I have been informed that the implant must remain covered under the gum tissue for at least three months in the lower jaw and six months in the upper jaw before it can implant. It has also been explained to me that once the implant is inserted, the entire treatment plan, including my personal and oral hygiene, must be followed and be completed on schedule. If this schedule is not carried out, the implant may fail. I understand the limitations of implant-supported crowns, bridges, and dentures depend specifically on the quality and quantity of the bone available in the ridges. In the anterior segment of the mouth where crowns, bridges, and dentures are used, esthetics may be compromised by the contour of the bony jaw ridge and gingival (gum) tissue. At the time of surgery, additional augmentation procedures may be necessary to enhance long term esthetic, functional and hygienic results. It is understood that further treatment or enhancement may be required to reach the desired results. However, there is no guarantee that with enhancement the desired results may ever achieve patient expectations.

I have been informed of the alternatives to Osseointegrated implants. The advantages and disadvantages of these procedures have been explained to me and I choose to proceed with the insertion of the Osseointegrated implant. I understand that there are normal sequelae (after-effects) and possible complications associated with this procedure and these have been explained to me. Some of the expected post surgical events may be swelling, bruising, pain, bleeding, functional and esthetic challenges with interim prosthesis (may not fit very well, will require adjustments, may not look terrific), and down time. I understand that I may need to arrange my personal schedule to allow time for recovery and rest post-operatively. There are probable post-surgical complications as well which include infection, rejection of implant, nerve damage, sinus problems, recession around adjacent teeth, increased sensitivity around adjacent teeth, difficulty opening mouth, damage to adjacent teeth, opening of sutures, allergic reaction to medications and swallowing of instruments or implant parts. The outcome of these complications are entirely unpredictable and the patient must accept that this could be a permanent outcome of surgery. My experience have shown most of these complications are temporary outcomes and a normal state eventually returns.

Although a good cosmetic result is planned for, it cannot be guaranteed. I also understand that any of the treatment complications may alter the treatment goals and other treatment options may be necessary. I also understand that problems may arise during the procedure which may prevent placement of the implant. The rejection of an implant is possible and would necessitate its removal.

Should this happen, I understand that it may be possible to insert another implant after a suitable healing period. A minimum fee will be assessed to cover expenses only.

I understand the costs involved with this treatment plan and the limitations of dental/medical insurance for implantology treatment plans.

I CERTIFY THAT I HAVE AND THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THIS PROCEDURE AND THE EXPLANATION REFERRED TO OR MADE. MY DECISION TO PARTAKE IN THIS PROCEDURE HAS BEEN MY OWN, AND HAS BEEN MADE WITHOUT DURESS OF ANY KIND. I UNDERSTAND THAT I WILL RECEIVE A COPY OF THIS DOCUMENT, IF REQUESTED.

The patient is a resident of Ontario, OR THE DECLARATION BELOW HAS BEEN SIGNED.

_____	_____	_____
Signature of Patient	Parent (or Guardian)	Date

To be completed for patient who resides outside Ontario.

I understand that Surgical Operation/Dental Treatment/ Diagnostic Tests and services are to be performed in Ontario, and that the Courts in the Province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or course of action including, but not limited to claim for breach of contract or any alleged negligence arising from the Surgical Operation/Dental Treatment/ Diagnostic Test. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of Ontario only, and hereby submits to the jurisdiction of the courts of the Province of Ontario.

The relationship between the patient and Dr. H. Kupeyan, its employees, agents and all the members of its staff shall be governed by and construed in accordance with the laws of the Province of Ontario.

I understand and agree to all the above.

_____	_____
Signature of Patient	Patient (or Guardian)