

Informed Consent

By signing the informed consent form, I acknowledge and agree to the following:

1. **Clinician's Observation** note: "*Language/Communication: English fluent [Initial] ; Interpreter required/present [Initial] ; Visual aids used [Initial].*"
2. I have been given the opportunity to have a support person, interpreter, or Elder present.
3. I have with me an interpreter/elder (*Name*) to ensure I understand my Medical Problems as they relate to my possibly having Dental Implants placed in the future. *[Initial*
4. I affirm that they have **accurately answered the Medical Health and Medication Questionnaire** provided by *[Dr Name]*, disclosing all known medical conditions, previous surgeries, allergies, and a comprehensive list of all prescription and over-the-counter medications and supplements I am currently taking.
5. I confirm that *[Dr Name]* has supplied me with extensive **written answers and notes** detailing how my specific medical health and medications may affect my success, safety, healing, and long-term prognosis of my dental implant treatment.
6. I confirm that each answer indicates why my medical history and medications pose a **High, Medium** or **Low** risk for my dental implant success.
7. I affirm I have had the opportunity to ask *[Dr Name]* questions **regarding how my medical health may affect my dental implants**, and all of my questions have been answered to my satisfaction.
8. I am **fully satisfied** that I have been informed of and understand the specific risks associated with the placement of dental implants as it relates to my medical history and medications
9. While no treatment plan has been suggested as of yet, I understand that, as with any surgery, there are inherent risks, including but not limited to: pain, swelling, bleeding, infection, nerve injury (potentially causing temporary or permanent numbness), delayed healing, damage to adjacent teeth or structures, and the risk of the dental implant failing to integrate with the bone (failure).
10. Should I wish to proceed with further treatment, I understand that I have the option to decline treatment, and that the risks of not proceeding will be explained to me.
11. Should I wish to proceed with further treatment, I understand that I have the option to see a specialist.
12. Should I wish to proceed with further treatment, understand that an estimate of fees will be provided before treatment begins, and that clinical changes during surgery may affect the final cost.
13. I have demonstrated my understanding of the risks by describing them back to *[Dr Name]* in my own words.

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Notes Regarding Medical Problems and Dental Implants

Condition 1 (e.g., Heart Attack): _____ **Risk:** [] High [] Med [] Low *Impact on treatment: [e.g., Consideration of anticoagulants/stress reduction protocol]*

Condition 2 (e.g., Smoking): _____ **Risk:** ☐ High ☐ Med ☐ Low *Impact on treatment: [e.g., 2.5x higher risk of failure/delayed healing documented]*

Condition 3 (e.g., Bisphosphonates): _____ **Risk:** ☐ High ☐ Med ☐ Low *Impact on treatment: [e.g., Risk of MRONJ discussed]*

Date:

Start Time:

End Time:

Patient Name:

Patient Signature:

Translator/Elder Name:

Translator/Elder Signature:

[Dr Name]:

[Dr Name} **Signature:**