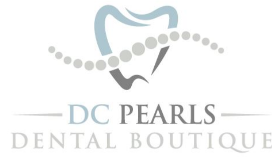
CONSENT Implant Removal



Consent for Implant Removal

Patient's First Name *

Patient's Last Name *

I hereby authorize Dr. Ardekani and any associates to remove implant(s) on tooth/teeth number(s) *

The removal of an implant is a surgical procedure. As with any surgical procedure there are some risks.

These risks include, but are not limited to the following:

1. Swelling and/or bruising and discomfort in the surgical area.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment.
4. Trismus, or limited jaw opening due to inflammation or swelling, most common after wisdom tooth extraction. Sometimes this is a result of jaw joint discomfort (TMJ), especially when a TMJ disorder already exists.
5. Bleeding - significant bleeding is not common, but persistent oozing can be expected for several hours. Serious complications are not expected. Those which do occur are most often minor and can be treated. I also give my permission to receive supplemental membranes, bone grafts, or other types of grafts to build up the ridge of my jaw thereby assisting in placement, closure, and security of future placement of implant, which may require additional charges.

Please do not hesitate to ask the doctor or the staff if you have any questions.

*

Date *

12/10/2021

Printed name if signed on behalf of the patient

Relationship