SIMCOE DENTAL IMPLANTS

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INFORMED CONSENT FOR FULL-ARCH IMPLANT TREATMENT

All-on-X / Full-Arch Implant-Supported Prosthesis

Patient's Full Name: _____

Date: _____ **Date of Birth:** _____

> *Please initial each section after reading. If you have any questions, ask Dr. Filo before initialing. Do not initial anything you do not fully understand.*

You have been provided with information about your proposed implant treatment so that you can make an informed decision about whether to proceed. By initialing and signing this form, you acknowledge that you understand the nature of the proposed treatment, the known risks and complications associated with it, and the available alternative treatments.

1. IMPLANT-SUPPORTED FULL-ARCH PROSTHESIS

Initial: _____

Dr. Filo has examined my mouth and made treatment recommendations for replacing my missing teeth. Alternative forms of treatment and their associated risks and benefits have been explained to me, including the option of doing nothing. I have had all of my questions answered to my satisfaction. I have been advised that I may seek additional care to preserve any teeth currently remaining in my mouth, including periodontal (gum disease), endodontic (root canal), orthodontic, and/or general dental care. Having considered these options and being fully informed, I have elected to proceed with an Implant-Supported Full-Arch Prosthesis for my upper jaw, lower jaw, or both. I understand that this is a surgical procedure and I have been informed of what is necessary to accomplish the placement of multiple implants. I understand that no guarantees can be made regarding the success of this surgical procedure, and I agree to follow all pre- and post-operative instructions, knowing that failure to do so may result in implant failure.

2. RISKS AND POSSIBLE COMPLICATIONS

Initial: _____

I have been informed of the possible risks and complications associated with this procedure, including those related to anesthesia and medications. These complications may include, but are not limited to:

- Pain, swelling, bruising, and post-operative discomfort
- Post-operative infection, including sinus infection
- Temporary or permanent numbness of the lips, chin, tongue, or cheek
- Vein inflammation (phlebitis), bone fractures, or delayed healing

- Penetration of the sinus cavity (upper jaw) requiring corrective treatment
- Allergic reactions to materials, medications, or anesthesia
- Failure of osseointegration (the implant failing to fuse with the bone)
- Difficulty with gum tissue healing
- For Zygomatic implants: temporary or permanent injury to the sinuses or eye socket, changes in vision, or in rare cases blindness
- Significant bleeding due to anatomical variations, which may require additional intervention
- Facial nerve injury, which may be permanent
- A slight alteration in facial appearance; in rare cases, scarring requiring corrective treatment
- Rejection or poor tolerance of the implant by bone or surrounding tissues, requiring removal
- In the event of implant failure, tissue and/or bone grafting may be required; the fallback option is conventional dentures

These complications are rare, and all precautions will be taken to prevent injury. However, in any surgical procedure, unforeseen complications can occur that may require referral to a specialist or medical professional.

3. HEALING AND POST-OPERATIVE COMPLIANCE

Initial: _____

My doctor has explained that there is no certain method of predicting my bone or tissue healing response following implant placement. I agree to follow all post-operative instructions and to notify the clinic immediately of any problems. I understand that, in rare cases, implants may not achieve sufficient stability for immediate loading with a fixed bridge. In such a case, I understand that I will be provided with a temporary denture during the healing period.

4. LIFESTYLE FACTORS AND MEDICAL HISTORY

Initial: _____

I understand that the use of tobacco products or excessive alcohol consumption can impair gum healing and reduce the long-term success rate of implant treatment. I agree to follow my doctor's recommendations in this regard. I understand that certain medical conditions may contribute to implant failure. I have provided a complete and accurate medical and dental history, and I will advise my doctor of any changes to my health prior to surgery. I agree to attend all recommended follow-up appointments and regularly scheduled cleanings. I understand that failure to maintain excellent home care and attend scheduled appointments creates a significant risk of implant loss, and that I will be responsible for the cost of replacing implants and/or restorations if this results from non-compliance. I am aware that I am welcome to seek a second opinion before consenting to any procedure.

5. AUTHORIZATION

Initial: _____

I consent to and authorize Dr. Filo and his staff to provide the following treatment: Implant-Supported Full-Arch Prosthesis. I understand that during and following treatment, conditions may become apparent that warrant additional or alternative procedures necessary for the success of my treatment. I approve any reasonable modification to the design, materials, surgical procedures, or care plan if it is determined to be in my best interest.

I understand that Dr. Elvis Filo is a general dentist with extensive training and experience in implant placement, restoration, and all related adjunct procedures including bone grafting, sinus lifting, and tissue grafting. Although he has completed thousands of implant procedures, I acknowledge that he is not an oral and maxillofacial surgeon or other recognized specialist, and I am choosing not to be referred to a specialist for this procedure.

6. PROSTHETIC EXPECTATIONS

Initial: _____

I understand that I will receive two sets of teeth as part of this treatment: a temporary acrylic prosthesis placed at or shortly after surgery, followed by a final prosthesis reinforced with a metal substructure. I understand that the physical properties of prosthetic teeth are subject to wear over time. Parafunctional habits (such as grinding or clenching), biting forces, and material limitations can contribute to tooth fracture or premature wear. There may be future costs associated with replacing or repairing the prosthesis.

7. ANESTHESIA

The following anesthesia options have been discussed with me: local anesthesia, local anesthesia with intramuscular sedation, local anesthesia with nitrous oxide/oxygen analgesia, local anesthesia with oral premedication, local anesthesia with intravenous (IV) sedation, and general anesthesia.

Initial: _____

Anesthetic risks include discomfort, swelling, bruising, infection, prolonged numbness, and allergic reactions. Intravenous site inflammation (phlebitis) may cause prolonged discomfort. Nausea and vomiting, although uncommon, are possible side effects of IV sedation. IV and general anesthesia are serious medical procedures and carry risks including cardiac irregularities, heart attack, stroke, brain damage, or in extremely rare cases, death.

IF IV OR GENERAL ANESTHESIA IS USED — YOUR OBLIGATIONS

Initial: _____

You MUST be accompanied by a responsible adult who will drive you home and remain with you until you have sufficiently recovered. This may be up to 24 hours. During this recovery period, you must not drive, operate machinery, or make important decisions, including signing legal documents.

Initial: _____

You must have a completely empty stomach. You must have NOTHING TO EAT OR DRINK for a minimum of FOUR (4) HOURS PRIOR TO YOUR PROCEDURE. Failure to comply may be life-threatening. However, you should take any regular medications (such as blood pressure medication or antibiotics) or any medications provided by this office with only a small sip of water, as directed.

Initial: _____

I understand that unforeseen conditions may arise during the procedure that will require an extension, modification, or in rare cases abandonment of the procedure. In such an event, I authorize my doctor and his staff to take whatever actions are deemed necessary and appropriate in the exercise of their professional judgment.

Initial: _____

I understand that my doctor is not the manufacturer or seller of the implant device itself, and makes no warranty or guarantee regarding the success or failure of the implant or its associated components. A perfect result cannot be guaranteed or warranted.

8. BONE GRAFTING AND SINUS LIFT (WHERE APPLICABLE)

On occasion, supplemental bone material is used to augment the patient's existing bone. The use of such material may involve additional risks including rejection of the donated graft material and, in remote cases, disease transmission from processed bone. If there is insufficient natural jawbone, a sinus lift procedure may be required. This involves opening the sinus cavity in the upper jaw and placing bone material — which may be the patient's own bone and/or specially prepared donated bone or bone substitute — to create adequate height for implant placement.

9. FINAL ACKNOWLEDGMENT AND CONSENT

Initial: _____

I have read and fully understand all of the information contained in this Informed Consent for Full-Arch Implant Treatment. I certify that I read and write English and that all blanks were completed prior to my initialing and signing this form. All of my questions have been answered to my satisfaction by Dr. Filo, and knowing the risks, I freely consent to the proposed treatment.

Signatures

_____	_____
Patient Signature	**Date**
_____	_____
Witness Signature	**Date**
_____	_____
Doctor / Authorized Staff Signature	**Date**

If the patient is a minor or otherwise lacks capacity to provide consent:

_____	_____
Guardian / Authorized Representative Signature	**Relationship to Patient**