

South Hill Periodontics

ANTHONY G. GIARDINO, D.D.S., M.S. • Diplomat, American Board of Periodontology
DWIGHT L. JOHNSON, D.M.D., M.S. • Diplomat, American Board of Periodontology
2700 Southeast Blvd. • Suite 210 • Spokane, WA 99223 • Phone (509) 536-7032

CONSENT FOR IMPLANT TREATMENT

- I authorize Dr. Giardino/Dr. Johnson and any such assistants selected by them to render treatment pertaining to oral implant placement. I understand during the course of this procedure(s), unforeseen conditions may necessitate an extension or deviation from the originally planned procedure, and I authorized the above-mentioned doctor or selected assistant to perform or provide any treatment or care needed in his professional judgment. I further understand this may result in an additional fee.
- I have been informed of possible alternatives (if any) to treat my condition, which includes doing nothing at all, and I understand the effects of these alternatives.
- I have been informed there are complications associated with this procedure, which may be temporary or permanent. These include numbness or tingling of the lower lip, chin or tongue, bleeding, swelling, bruising, pain, infection, damage to existing teeth or dental work and failure of the implant(s).
- I have been informed success cannot be guaranteed and failure of the implant(s) can occur, and may or may not be replaceable.
- I have been informed the success of the implant(s) depends on continued care, which includes regular exams, x-rays, maintenance visits, as well as diligent home care.
- I have been informed any tampering with the implant(s) by an unauthorized practitioner, or the use of unauthorized materials, can cause the failure of the implant(s).
- I agree to follow all instructions given to me by the doctor or assistants that I will arrange for transportation to and from the office following the procedure. I further agree not to operate any vehicle or hazardous equipment while taking any prescription medication, which causes drowsiness.
- I have fully disclosed any medical information or condition that could relate in any way to the candidacy for this procedure or have an effect on its success.
- I understand the fees, as agreed upon for this procedure, do not include the restorations and these additional restorative fees are payable to a separate practitioner.
- I consent to the taking of any photos during the course of this procedure to use for teaching purposes, including demonstration and/or publication.

I, _____ certify that I read English and fully understand the information enclosed in this consent form and I authorized Dr. Anthony Giardino/ Dr. Dwight L. Johnson and staff to administer the necessary anesthesia and perform the following procedure(s):

Patient/Guardian Signature: _____ Date: _____

Confirmed: _____ Date _____