FLYNN DENTISTRY
KAYSVILLE
COSMETIC & FAMILY DENTISTRY
497-0619

Patient's Name: _____ , _____ _____
Last First Initial

The following information is necessary to safely receive dental treatment and will be held completely confidential. Since a change in medical condition or medication can affect dental treatment, I agree to notify the office of any future changes.

YES NO **Allergies** to <u>medications</u>? (ie. Penicillin): _____ Other **Allergies** (ie. Metals):?_____

Dental Implant Surgery, Implant integration and long term success depends on a healthy environment. The following medical conditions can increase complications and inhibit success. Please **CIRCLE** if you HAVE or HAVE HAD any of the following conditions/habits and provide relevant details

Medical Conditions with increased risk of Dental Implant failure:

<u>High Risk</u>:

YES NO Tobacco use (any form): Quantity/day_____ **#1 cause of implant failure** (2x failure rate)
YES NO Diabetes: Type:_____ Controlled Diabetes vs. Uncontrolled Diabetes
YES NO High Cholesterol: Well controlled with medication YES NO
YES NO Poor Oral Hygiene

<u>Strong Caution</u>:

YES NO Recent Myocardial Infarction (Heart Attack) or Stroke— Date/Details: _____
YES NO Immunosuppression/Bleeding Issues: _____
YES NO Valvular Prosthesis Surgery— Date/Details:_____
YES NO OSTEOPOROSIS Treatment— Date/Details/How long?_____
YES NO History of **INTRAVENOUS Bisphosphonate Use** (typically due to cancer tx)
IV Drugs: ***Aredia*** (pamidronate)***, Bonefos, Zometa*** (zoledronate)***, Other:***_____
YES NO History of **Oral Bisphosphonate Use**
Oral Tablets: ***Actonel*** (risedronate)***, Boniva*** (ibandronate)***, Didronel, Fosamax***(alendronate)***, Fosamax Plus D, Skel'd, Other:***_____
Warning: I understand that bisphosphonate medications for the prevention of osteoporosis may result in complications of non-healing of the jaw bones following oral surgery, dental implant placement or tooth extractions
YES NO Active treatment of a Cancerous Malignancy— Date/Details:_____
YES NO Long term steroid use— Date/Details:_____
YES NO Psychiatric Illness— Details:_____
YES NO Bruxism/Clenching
Warning: chronic intense trauma will cause implants to fail, especially long span fixed cases (ie. implant bridges, All on 4) as well as mini-implants; Locator Over-dentures = typically OK; Bite guard therapy may be advised to lower risks/trauma
Warning: Loose teeth - If neighboring teeth are mobile, new implants will carry the load and in consequence the loose teeth will get looser and may begin to fall out (treatment plan accordingly)
YES NO Previous Dental implant treatment Failure— Date/Details: _____

Treatment Plan: _____

CONSENT TO PROCEED

I hereby authorize Dr. Flynn and/or such associates or assistants as he may designate to perform procedures as may be deemed necessary or advisable in conjunction of my receiving dental implants or of another individual for which I have responsibility. Alternatives to implant therapy have been explained, and I desire implant placement to replace missing teeth. I have been informed about the implant surgery procedure. I understand that although approximately 95% of implants successfully integrate into bone, in a few instances implants fail and must be removed. **I understand that Excessive Smoking, Alcohol or Sugar consumption as well as Poor Oral Hygiene may effect healing and limit the success of implants.**

I have been informed of the possible risks and complications involved with implant surgery, drugs, and anesthesia. I have been told that all of these complications occur very infrequently. Such potential complications include pain, swelling, infection and transient discoloration. Numbness of the lip, tongue, chin, cheek or teeth may occur in a few cases. The exact duration of numbness is not predictable and infrequently may be irreversible. Also possible is injury to adjacent teeth, bone fractures, delayed healing and/or allergic reactions.

I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgement of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials or care, if it is felt this is for my best interest. I do voluntarily assume any and all possible risks, if any, which may be associated with surgical treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

I attest to the accuracy, truthfulness and completeness of the medical history information on this page. I also hereby attest that I have read the above disclosed 'Consent to Proceed' statement and assume any and all possible risks associated with obtaining dental treatment.

Patient's (or Guardian's) Signature: **X** _____ Date_____
Witness's Signature: _____ Date_____

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