CONSENT FOR SURGERY

1. I ______________________________ have been informed and understand the purpose and nature of implant placement, bone grafting, or other oral surgery procedure.

2. The doctor, associates, and assistants of Dr. Kie Gardner, D.D.S. will perform the following procedure:
   ______________________ in the ______________________ area, as discussed during the consultation appointment.

3. I agree to follow the verbal and written post-operative instructions given to me by the doctor and staff. If there are instructions that I do not understand, I will call the office. I can expect some swelling and discomfort post-operatively.

4. I have been informed of and understand the possible risks and complications involved with implant surgery, drugs, and anesthesia. Such complications include pain, swelling, infection, bruising, bone loss, bone graft not maturing into usable bone to place the implant, rejection of the implant, failure of the implant due to design or placement of the permanent prosthesis on the implant unrelated to the placement procedure, periodontal disease, paraesthesia (loss of feeling due to nerve trauma during surgery or swelling caused by the surgery.)

5. Smoking is to be avoided for the time specified by Dr. Gardner since it increases the heat in the surgical area and significantly lowers the body's ability to heal the site. Failure to do this might result in poor healing around the implant, and this is not the responsibility of the doctor. I understand that smoking, excessive alcohol or sugar might affect gum healing and might limit the success of the implant. I also agree to follow the doctor's home care instructions and visit the doctor for regular hygiene appointments as instructed.

6. I understand that as with my natural teeth, there are no guarantees of the success of this dental implant and that in some instances implants fail and must be removed. I understand one-year examinations are required to help insure the success of the implant.

7. **If general anesthesia is used, I agree to the type of anesthesia, depending on the doctor's choice. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.**

8. I consent to photography, filming, recording and x-rays of the procedure for the advancement of implant dentistry, provided my identity is not revealed.

______________________	______________
Signature of Patient or Guardian	Date
______________________	______________
Signature of Doctor	Date
______________________	______________
Signature of Witness	Date