



Consent for Implant Surgery

I hereby authorize **Faisal A. Quereshey, M.D., D.D.S.**, as a qualified Maxillofacial Surgeon, and such assistants as he may designate, to perform upon:

Please initial each paragraph after reading. If you have any questions, please ask Dr. Quereshey BEFORE initialing:

____1. An operation for the purpose of improving function and/or appearance and overall quality of life, with respect to the following condition(s):

Partial or complete edentulism 3. Failed dental prosthesis
Masticatory Dysfunction 4. Speech alterations

____2. The specific proposed operation, to which I agree to submit, is as follows:

Surgical Placement of Osseointegrated Implant(s) sites: _____

____3. I hereby swear that the operation(s) to correct the aforementioned condition(s) have been thoroughly explained to my satisfaction and, in addition, the specified risks involved have been explained and include, among others outlined, the following major complications:

Pain/Swelling 5. Temporary or permanent nerve injury
Damage to adjacent teeth/roots 6. Altered sensation, numbness, tingling in lips/teeth/gums
Bleeding/Bruising 7. Bone loss around the implant or implant failure
Infection and/or sinusitis 8. Unable to wear dental prosthesis (temporarily after surgery)
Restricted mouth opening

____5. I understand that this a two phase process, with the implant placement (Phase I) performed by **Faisal A. Quereshey, M.D., D.D.S.** I also understand that a period of at least three (3) to six (6) months will be needed for healing between the bone and the implant; the exact time to be determined by my surgeon. At that time a second surgical (minor) procedure is required to uncover the top of the implant(s). **The entire treatment must be followed and completed on schedule.** Then, the prosthetic Phase II will be performed by Dr. _____, and that a separate charge will be made by that office for the dental restorations.

____6. It has been explained to me that during the course of such operation(s), unforeseen conditions may be revealed which necessitates either an extension of the aforementioned operation(s), or modified procedure(s) other than those listed. I therefore authorize, and do request, that **Faisal A. Quereshey, M.D., D.D.S.**, his assistants or designees, perform such surgical procedure(s) that are necessary and/or desirable in the exercise of professional judgement. The authority granted in this item shall also include treatment of all conditions, which are presently not known to **Faisal A. Quereshey, M.D., D.D.S.** but becomes apparent at the time of the operation.

____7. I furthermore know and understand that the quality of bone and the predictability of the success cannot be determined until an attempt is made to prepare the bone for implant placement.

____8. I understand that excessive smoking and alcohol may affect gum healing and may limit the success of the implant. I agree to follow by doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

I certify that I have had the opportunity to fully read this consent. I have been given the opportunity to ask questions about my condition, alternative forms of treatment and risks of non-treatment, the procedures used, and the risks and hazards involved. I

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*Fellow American College of Surgeons • Diplomate American Board of Oral and Maxillofacial Surgery
Board Certified American Board of Cosmetic Surgery • Fellow American Academy of Cosmetic Surgery*



VISAGE SURGERY CENTER

*Oral & Maxillofacial Surgery
Facial Cosmetic Surgery*

FAISAL A. QUERESHY, MD, DDS, FACS, INC.
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am likewise satisfied that any and all possible alternative methods of treatment have been thoroughly explained. My signature below indicates my agreement and understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

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