DR. FAIZAN ABDUL HUSSAIN LAKHDIR

CONSENT FORM FOR IMPLANT (Surgeon's Copy)

Serial No	**Date**	**CNIC / MR No.**
Hospital / Clinic		
Patient Name	**Age**	**Gender**
Address	**Contact No**	
Medical Risk Details		

Patient Responsibility

I understand that success of implant treatment depends on proper oral hygiene, regular follow-up visits, medicines as prescribed, diet instructions, and avoiding harmful habits such as smoking or chewing hard objects.

If I do not follow the given instructions, miss follow-up visits, discontinue treatment, delay the prosthetic phase, or fail to maintain oral hygiene, the result may become unpredictable.

If I come with an incomplete implant case, previous surgery, previous grafting, previous implant placement, or partial treatment done from another clinic / hospital, I understand that the surgeon will assess and manage the case based on the available condition. The surgeon will not be responsible for unpredictable results, hidden complications, or problems arising from previous treatment, incomplete records, or patient non-compliance.

Consent Statement

I have been informed that I require dental implant treatment for replacement of missing tooth / teeth. The procedure, benefits, limitations, alternatives, cost, and possible complications have been explained to me in simple words.

The procedure may be performed under local anaesthesia, with or without epinephrine/adrenaline, depending on my medical condition and the surgeon's clinical judgment.

Additional Procedure Requirement

I understand that after clinical and radiographic assessment, implant placement is planned according to the available bone and soft tissue condition. However, during or after surgery, it may become necessary to perform additional procedures such as:

- Membrane placement
- Sinus lift / ridge expansion, if required
- Bone grafting
- Soft tissue grafting or flap modification
- Additional X-rays / CBCT / investigations
- Delayed implant placement or staged treatment

I understand that these additional procedures may be required even after initial assessment and may involve extra cost, healing time, appointments, or referral.

Possible Risks and Complications:

I understand that possible complications may include:

- Pain, swelling, bleeding, bruising, infection, or delayed healing
- Failure of implant to integrate with bone
- Need for implant removal, replacement, bone grafting, or further surgery
- Temporary or rarely permanent numbness of lip, chin, gums, or tongue
- Sinus involvement in upper jaw implants
- Gum recession, food lodgement, screw loosening, prosthesis fracture, or aesthetic compromise
- Failure due to smoking, poor oral hygiene, uncontrolled diabetes, bone disease, heavy bite forces, or non-compliance
- Injury to nearby teeth, gums, sinus, nerves, or bone

Patient Declaration

I confirm that the procedure, benefits, risks, alternatives, limitations, possible additional procedures, and patient responsibilities have been explained to me. I have had the opportunity to ask questions, and my questions have been answered.

I understand that no guarantee has been given regarding implant success, healing, final appearance, comfort, or long-term survival. I consent to dental implant treatment as planned. Surgeon, hospital or staff will not be responsible for any mentioned complications or emergency above.

Patient / Guardian Name	**Patient / Guardian Signature**
Doctor Name and Signature	**Witness Name and Signature**

DR. FAIZAN ABDUL HUSSAIN LAKHDIR

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