

**This is one of the largest decisions in dentistry, and much of it cannot be undone.** Removing the remaining teeth in an arch and reshaping the bone is permanent. Please read this form, or ask us to read it to you, and do not sign until every question has been answered. You may change your mind and stop at any point before surgery begins.

Patient name  Date of birth  Chart / MRN   
Today's date  Time  Treating surgeon

## 1. MY TREATMENT PLAN

Diagnosis / reason for treatment

Arch(es) and teeth to be removed

☐ Upper arch (maxilla) ☐ Lower arch (mandible) ☐ Both arches

Implants planned — upper  lower  Number may change during surgery

**Implant types planned** (the final combination is decided during surgery, based on the bone actually found):

☐ Standard axial implants ☐ Tilted / angled implants ☐ Pterygoid implants  
☐ Zygomatic implants ☐ Narrow or transitional implants ☐ Trans-nasal / trans-sinus

**The plan also includes:**

☐ Removal of all remaining teeth in the arch ☐ Bone reduction (alveoloplasty) ☐ Bone or soft tissue grafting ☐ Guided surgery with a surgical guide  
☐ Same-day fixed provisional (immediate load) ☐ Delayed loading — removable denture first ☐ Digital scan / photogrammetry ☐ Extraction of failing implants or hardware

Provisional (temporary) prosthesis material  Planned time to final

Final prosthesis material  Restorative dentist, if not this office

☐ Titanium bar with acrylic and denture teeth ☐ Monolithic zirconia ☐ Zirconia on a titanium bar ☐ Porcelain-fused / other — specify above

**Alternatives we discussed** — including doing nothing at all, and what is likely to happen with each:

☐ No treatment / keep current teeth ☐ Save some or all teeth with periodontal, endodontic or restorative care ☐ Conventional complete denture  
☐ Implant-retained removable overdenture (2–4 implants) ☐ Segmented fixed bridges on more implants ☐ Grafting first, then implants later

Alternatives, in my surgeon's words

## 2. WHAT "ALL-ON-X" MEANS, AND WHAT IT DOES NOT MEAN

- The "X" is not fixed.** It is the number of implants needed to support the bridge. The final number, position and angle are decided during surgery, once your surgeon can see and feel the bone. Fewer or more implants than planned may be placed.
- Same-day teeth are temporary teeth.** If your implants are stable enough on the day of surgery, a temporary fixed bridge is attached. It is made of acrylic or printed resin, it is not the final result, and it is expected to chip, stain, wear or break during the months of healing. The final bridge is made later and will look and feel different.
- This is a prosthesis, not a set of new natural teeth.** The bridge is a device that is screwed onto implants. It does not feel, chew or age like natural teeth. It requires daily cleaning under the bridge, professional maintenance, and eventual repair and replacement.
- What is removed cannot be put back.** Extraction of the remaining teeth and reduction of the jaw bone are permanent. If this treatment fails, the options remaining to me may be fewer and more difficult than the ones I have today, and a conventional denture on a reduced ridge may fit poorly.

**Longevity, in plain numbers.** Implants often last a long time; the bridge on top of them does not last as long. In published follow-up studies of full-arch fixed prostheses, essentially every prosthesis needed at least one repair by about six years, and roughly 4 out of 5 prostheses were still in service at 5 years and about 3 out of 5 at 10 years. These figures come from studies of other patients and are not a promise about my own result. **Replacement of a worn or fractured bridge is additional treatment at additional cost.**

### 3. RISKS OF THE SURGERY

No surgery is risk-free, and no result can be promised or guaranteed. This list cannot include every possible complication.

- **Common, and usually temporary:** considerable pain, swelling and bruising of the face and neck for several days — usually more than after a simple extraction; bleeding and oozing for the first day; stiff jaw and limited mouth opening; sore throat; cracked corners of the mouth; bruising that can track down the neck and chest; difficulty eating for weeks.
- **Less common:** infection needing antibiotics, drainage or a second procedure; wound opening and slow healing; damage to the lips, cheeks, tongue or corners of the mouth; jaw joint (TMJ) pain, clicking or locking; hematoma; scarring; small pieces of bone that work their way out later; allergic or other adverse reaction to a medicine or material.
- **Uncommon, but serious: nerve injury** — numbness, tingling, burning or pain of the lower lip, chin, gums or tongue, and/or a change or loss of taste. The lower jaw carries the higher risk, and bone reduction brings the surgery closer to the nerve. This usually improves over weeks to months, but it can last longer and in some cases is **permanent**; an opening between the mouth and the sinus or nose; fracture of a thin, atrophic lower jaw, which may require hospital treatment and plating; infection spreading into the face or neck; heavy bleeding.
- **Rare: medication-related osteonecrosis of the jaw (MRONJ)** — bone that will not heal and stays exposed; the risk is higher with bone-strengthening or anti-cancer drugs (alendronate, zoledronic acid, denosumab and similar) or previous radiation to the jaws; permanent change in facial appearance; life-threatening complications.

If **zygomatic, pterygoid or trans-sinus implants** are used, these additional risks apply:

- sinus infection or long-term sinusitis, sometimes needing ENT treatment or removal of the implant; oro-antral communication; nasal congestion or discharge;
- injury to the infraorbital nerve causing numbness of the cheek, side of the nose or upper lip;
- penetration into the orbit (eye socket) or, very rarely, injury to the eye or its contents; bruising around the eye; temporary double vision;
- these implants are technically difficult to remove if they fail, and removal is a larger operation.

### 4. RISKS SPECIFIC TO FULL-ARCH IMPLANT TREATMENT

- **Not enough stability on the day.** If the implants are not firm enough to carry a bridge immediately, **same-day fixed teeth will not be delivered.** I will wear a removable temporary denture, which sits on the healing gums and is often uncomfortable, for several months.
- **Implant failure.** One or more implants can fail to fuse with the bone, or can fail later. Depending on which implant and when, this may mean additional surgery, additional implants, grafting, a remake of the bridge, a return to a removable denture, or — if enough implants fail — loss of the whole plan.
- **Bone reduction is permanent.** Reshaping the ridge lowers it and changes its form. A denture made before surgery will not fit afterwards, and a conventional denture on a reduced ridge is usually less stable than it was before.
- **Speech and adaptation.** Most people develop a lisp or altered speech at first and adapt over weeks. Some do not fully adapt. Air or saliva may escape at the sides. The bulk of the bridge and its position may change how I sound.
- **Cleaning and food trapping.** There is a space under the bridge, and food and air pass under it. Cleaning requires a water flosser, superfloss or threaders, every day, for life. The bridge must be unscrewed and professionally cleaned periodically, which is a separate appointment and fee.
- **Gum and bone changes.** Peri-implant mucositis and **peri-implantitis** (inflammation with bone loss) can develop around the implants. Gums shrink over time, which may expose the metal, the junction between the bridge and the gum, or dark spaces — a particular concern if I have a high smile line. This junction may be visible when I smile or speak.
- **Prosthesis and hardware problems.** Chipping and wear of the teeth; fracture of the bridge or its framework; loosening or fracture of screws and abutments; staining of the access holes; a screw or fragment that is difficult to retrieve. **Grinding and clenching (bruxism) sharply increases all of these**, and a protective night guard is usually required — and is my responsibility to wear.
- **Bite, joint and opposing arch.** The bite and the vertical height of my face may be changed on purpose. This can affect the jaw joints and muscles. A hard bridge chewing against natural teeth or another prosthesis can wear or damage the opposing arch, which may then also need treatment.
- **Appearance.** The shape, size, color and lip support of the final bridge are limited by the position of my implants, the bone and the space available. The result may not match the appearance I imagined, and there are limits to how much it can be changed once the implants are placed.
- **Systemic and habit factors.** Smoking or vaping, uncontrolled diabetes, bruxism, steroids or drugs that lower immunity, previous radiation, and poor hygiene all significantly increase the chance of infection, bone loss and failure of this treatment.
- **Imaging.** Implants and frameworks cause scatter on CT and MRI images. I should tell any future doctor or imaging center that I have them.

### 5. TIMELINE, MAINTENANCE AND WHAT MY FEE INCLUDES

|                                |                      |                                                      |                      |
|--------------------------------|----------------------|------------------------------------------------------|----------------------|
| Estimated total treatment time | <input type="text"/> | Approximate number of visits                         | <input type="text"/> |
| Recall / maintenance interval  | <input type="text"/> | Professional removal & cleaning of the bridge, every | <input type="text"/> |

**Included in my quoted fee:**

- |                                                         |                                                         |                                                     |                                                      |
|---------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Surgery and implants           | <input type="checkbox"/> Provisional (temporary) bridge | <input type="checkbox"/> Final bridge               | <input type="checkbox"/> Night guard                 |
| <input type="checkbox"/> Post-op visits for ____ months | <input type="checkbox"/> Annual maintenance visits      | <input type="checkbox"/> Repairs to the provisional | <input type="checkbox"/> Repairs to the final bridge |

**NOT included, and billed separately:**

## CONSENT FOR FULL-ARCH IMPLANT TREATMENT (ALL-ON-X)

Patient: \_\_\_\_\_

- |                                                            |                                                                        |                                                           |                                                                 |
|------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Anesthesia by an outside provider | <input type="checkbox"/> Replacement of a worn or broken bridge        | <input type="checkbox"/> Additional implants if one fails | <input type="checkbox"/> Grafting not planned today             |
| <input type="checkbox"/> Treatment of the opposing arch    | <input type="checkbox"/> Repairs caused by grinding, injury or neglect | <input type="checkbox"/> Sedation for later visits        | <input type="checkbox"/> Records transferred to another dentist |

Written warranty or remake policy, if any \_\_\_\_\_

**I understand that this treatment is a lifelong commitment, not a one-time procedure.** If I do not keep my maintenance appointments, clean under the bridge daily, and wear a night guard if one is prescribed, my risk of bone loss, hardware fracture and failure rises sharply, and correcting the result may be at my own expense.

## 6. ANESTHESIA AND SEDATION

Type I have chosen, after discussing the options:

- |                                                |                                                       |                                                  |                                               |                                                              |
|------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Local anesthesia only | <input type="checkbox"/> Nitrous oxide (laughing gas) | <input type="checkbox"/> Oral / minimal sedation | <input type="checkbox"/> IV moderate sedation | <input type="checkbox"/> Deep sedation or general anesthesia |
|------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|

Anesthesia provided by \_\_\_\_\_

NYS certificate / license # \_\_\_\_\_

- **All anesthesia, including local:** allergic or adverse reaction to a drug; pain, swelling, bruising or lasting numbness where an injection or IV is placed; nerve injury from an injection; nausea and vomiting; dizziness, confusion, poor coordination or grogginess that can last into the next day; being aware of parts of the procedure.
- **Sedation and general anesthesia also carry:** trouble with breathing or the airway; low blood pressure or an irregular heartbeat; stomach contents entering the lungs; sore throat, hoarseness, or injury to teeth, lips or gums if a breathing tube or airway device is used; and — rarely — heart attack, stroke, brain injury, or death.

If you are having any sedation or general anesthesia, initial each line:

- |                          |                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | I have had <b>nothing to eat or drink for at least 6 hours</b> (clear liquids only up to the time I was told). I understand that eating or drinking before sedation can be life-threatening.                                                                                                                                                                    |
| <input type="checkbox"/> | I have told this office about <b>every</b> medicine and supplement I take, including blood thinners, bone-strengthening drugs, steroids, herbal products, and any <b>GLP-1 medicine</b> such as semaglutide (Ozempic, Wegovy), tirzepatide (Mounjaro, Zepbound) or liraglutide — these can keep food in the stomach and change the fasting instructions I need. |
| <input type="checkbox"/> | I took my usual prescribed medicines exactly as instructed, with small sips of water.                                                                                                                                                                                                                                                                           |
| <input type="checkbox"/> | A responsible adult is with me today, will drive me home, and will stay with me until I have recovered.                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> | For <b>24 hours</b> I will not drive, operate machinery or power tools, drink alcohol, be the only adult caring for a child, or sign legal or financial documents. I understand the medicines may not fully wear off for a day.                                                                                                                                 |
| <input type="checkbox"/> | I am not pregnant, or I have told the office that I may be pregnant or am breastfeeding.                                                                                                                                                                                                                                                                        |

## 7. MEDICINES AND PAIN CONTROL

Most oral surgery pain is controlled best by alternating **ibuprofen and acetaminophen** on a schedule, not by opioids. If an opioid is prescribed for you, we have discussed the following:

- It is for **short-term use only**. New York limits an initial opioid prescription for acute pain to a 7-day supply.
- Opioids cause drowsiness, constipation, nausea and slowed breathing, and can lead to **dependence, addiction and overdose** — the danger is much higher when combined with alcohol, benzodiazepines, muscle relaxants, sleep aids or other sedatives.
- Do not drive or work while taking them.
- Keep them **locked away** from children, teenagers, visitors and pets, and take what you do not use to a drug take-back site. Never share them.
- **Naloxone (Narcan)** reverses an overdose, is available without a prescription, and may be recommended for your home.
- Antibiotics can cause upset stomach, diarrhea, *C. difficile* infection, yeast infection, rash or a serious allergic reaction, and may make hormonal birth control less reliable.

- |                                                 |                                            |                                                   |                                                                      |
|-------------------------------------------------|--------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Opioid risks discussed | <input type="checkbox"/> No opioid planned | <input type="checkbox"/> Patient declines opioids | <input type="checkbox"/> History of substance use disorder disclosed |
|-------------------------------------------------|--------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------|

## 8. MY PART IN THE RESULT

- I have given a complete and accurate medical and dental history, including all conditions, all prescription and non-prescription medicines and supplements, allergies, recreational drug use and pregnancy, and I will report any change before surgery.
- I will follow the **soft diet** I am given — typically nothing hard, crunchy or chewy for the first 8 to 12 weeks. Biting into hard food with a temporary bridge is the most common cause of early failure.
- I have been told that **smoking and vaping** significantly increase the risk that these implants and this bridge will fail, and I have been advised to stop.

- I will clean under the bridge every day as instructed, keep every maintenance appointment, and wear a night guard if one is prescribed.
- I will call the office promptly about pain, swelling, a loose or clicking bridge, bleeding gums around the implants, or a broken tooth on the bridge, rather than waiting for my next visit.
- I understand that if I do not do these things I am much more likely to have a complication or lose the result, and that corrective treatment may be at my own expense.

## 9. WHAT I UNDERSTAND AND AGREE TO

- Dentistry and surgery are not exact sciences. **No one has promised or guaranteed me a particular result**, an exact appearance, a treatment length, or how long this will last.
- Once surgery has begun, my surgeon may find bone or anatomy that was not visible on the examination, x-rays or CT scan. **I authorize my surgeon to change the number, position, angle or type of implants, to add grafting, to withhold the same-day bridge, or to stop the procedure**, if in their professional judgment that is medically reasonable and in my best interest — including while I am sedated and cannot be asked.
- I may need more visits, more tests, referral to another specialist, further surgery, or hospital care.
- Surgical fees, anesthesia fees and prosthetic fees are separate, and additional or corrective treatment may cost more. Insurance may cover little or none of this treatment.
- Records, images, scans and models made in the course of my care are part of my dental record and are kept by the practice; I may request copies.
- **I may withdraw this consent and stop treatment at any time before surgery begins.**

Initial each of the following:

- ☐ I understand that my remaining teeth in this arch will be **removed permanently** and that bone will be reshaped, and that this cannot be reversed.
- ☐ I understand that the teeth placed on the day of surgery are **temporary**, and that the final bridge is made months later and will look and feel different.
- ☐ I understand that the bridge is a device that will require **daily cleaning, regular professional maintenance, repair, and eventual replacement at additional cost**.
- ☐ I understand that **implants can fail**, that a failure may require more surgery or a return to a removable denture, and that no one has guaranteed me otherwise.

## 10. PHOTOGRAPHS, IMAGES AND RECORDS — optional; initial only what you agree to

- ☐ Photographs, video, x-rays, scans and models may be taken and used **for my own diagnosis, treatment planning and dental record**. (Required in order to provide care.)
- ☐ They may also be used **without my name** for teaching, professional lectures, study clubs and publication in professional literature.
- ☐ They may also be used **without my name** on the practice website, in advertising and on social media. I understand that once an image is published online it may be copied and may not be possible to withdraw completely. I may revoke this in writing for future use at any time.
- ☐ I do NOT consent to marketing or social media use

## 11. LANGUAGE, QUESTIONS AND UNDERSTANDING

- Preferred language  Interpreter name / ID / service
- ☐ Discussion held in English ☐ Professional interpreter used ☐ Telephone / video interpreter
- ☐ Adult family member interpreted at my request ☐ Written materials provided

I have read this form, or it has been read to me in a language I understand. I had enough time to read it and to ask questions. My questions were answered in a way I understand. I was able to describe, in my own words, what is going to be done and what the main risks are. I am signing this freely, and I am not under the influence of alcohol, drugs or sedative medication at the time I sign. I have been offered a copy of this signed form.

## SIGNATURES

|                                              |             |                                                                                                               |             |
|----------------------------------------------|-------------|---------------------------------------------------------------------------------------------------------------|-------------|
| <div></div>                                  |             | <div></div>                                                                                                   | <div></div> |
| Signature of patient or legal representative |             | Date                                                                                                          | Time        |
| <div></div>                                  |             | <div></div>                                                                                                   |             |
| Print name                                   |             | If not the patient: relationship and legal authority (parent, guardian, health care proxy, power of attorney) |             |
| <div></div>                                  | <div></div> | <div></div>                                                                                                   | <div></div> |
| Interpreter signature (if used)              | Date        | Witness signature (optional)                                                                                  | Date        |

## CLINICIAN ATTESTATION

I personally discussed with this patient, or the patient's legal representative, the diagnosis; the nature and purpose of the proposed treatment; its reasonably foreseeable risks and benefits; the reasonable alternatives, **including no treatment**, and their risks and benefits; the anesthesia plan; and the expected maintenance and long-term commitment — in plain language, and through an interpreter where one was needed. I asked the patient to tell me in their own words what is planned and what the main risks are, and I am satisfied that they understood. I answered all questions. In my judgment the patient or representative has the capacity to decide and is consenting voluntarily. This discussion has been documented in the patient's record.

|                                                      |                     |               |             |
|------------------------------------------------------|---------------------|---------------|-------------|
| <div></div>                                          | <div></div>         | <div></div>   | <div></div> |
| Surgeon signature                                    | Print name          | NYS license # | Date / time |
| <div></div>                                          | <div></div>         | <div></div>   | <div></div> |
| Additional clinician or assistant present (optional) | Print name and role | Date          |             |

## ADDITIONAL DISCUSSION AND QUESTIONS ASKED — optional; part of the record

Anything discussed that is not covered above — the patient's specific questions and the answers given, material risks specific to this patient, findings reviewed, or a plan the patient declined:

## OFFICE USE

- |                                                           |                                                           |                                                              |                                                                     |
|-----------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Signed original scanned to chart | <input type="checkbox"/> Copy offered / given to patient  | <input type="checkbox"/> Pre- and post-op instructions given | <input type="checkbox"/> Medical history reviewed and updated today |
| <input type="checkbox"/> Medical clearance on file        | <input type="checkbox"/> Antibiotic prophylaxis indicated | <input type="checkbox"/> Anticoagulant protocol reviewed     | <input type="checkbox"/> PMP (I-STOP) checked, if prescribing       |

Consent obtained by  Date / time  Procedure date

*Retention: scan the signed original into the patient record before treatment begins, and offer the patient a copy. Re-confirm and re-date this consent if the treatment plan changes materially, if the anesthesia plan changes, or if more than 90 days pass before the procedure is performed.*