DENTAL IMPLANT TREATMENT CONSENT & AGREEMENT PACKAGE

1. Patient Information & Medical History Form

Personal Information

Full Name:

_____

Date of Birth: _____

NIC/Passport Number: _____

Phone Number: _____

Email Address: _____

Address:

_____

Medical History & Suitability Assessment

Question	Yes	No	If Yes, Provide Details
Do you have diabetes, osteoporosis, or immune disorders?	☐	☐	
Have you had radiation therapy to the head/neck area?	☐	☐	
Are you taking bisphosphonates or immunosuppressants?	☐	☐	
Are you a smoker or consume alcohol frequently?	☐	☐	
Do you have any history of gum disease or tooth loss?	☐	☐	
Are you pregnant or planning pregnancy during treatment?	☐	☐	
Do you have allergies (especially to metals or anesthesia)?	☐	☐	

I certify the above information is accurate. I understand that undisclosed conditions may affect treatment outcome.

Patient Signature: _____

Date: _____

Doctor's Name & Signature: _____

2. Dental Implant Treatment Consent Form

I, _____ (Patient Name), understand that dental implant treatment involves the surgical placement of artificial tooth roots into the jawbone, followed by a healing period and eventual placement of a crown or denture.

I acknowledge the following:

- Implants require sufficient bone and healthy gums.
- Surgical risks include swelling, bleeding, infection, and nerve damage.
- Healing can take 3–6 months or longer depending on individual health.
- Failure can occur due to smoking, infection, or improper oral hygiene.
- Multiple appointments and follow-ups are required.
- Crowns or dentures attached to implants may wear over time.
- CT scans or OPGs may be required for planning and review.

- Final restoration may differ slightly from natural teeth in color/shape.

I have been informed of alternative treatments (e.g., bridges, dentures) and voluntarily choose implants.

Patient Signature: _____
Date: _____
Doctor's Signature: _____

3. Pre-Treatment Instructions & Guidelines

- Refrain from smoking or alcohol 1 week before and after surgery.
- Inform the doctor of all current medications.
- Eat lightly and arrange transportation on surgery day.
- Fast for 6 hours before if under sedation.
- Oral infections must be treated before implant placement.

4. Post-Treatment Care & Responsibilities

- Take prescribed medications as instructed.
- Avoid hard foods near the implant site for at least 4 weeks.
- Maintain oral hygiene; use soft brush and chlorhexidine rinse if advised.
- Attend all follow-up appointments as scheduled.
- Report symptoms such as severe pain, bleeding, or swelling.

5. Financial Agreement & Refund Policy

- Full payment is required before the final crown/denture is issued.
- A non-refundable deposit is required for scheduling surgery.
- Costs for surgical guides, scans, or lab work are non-refundable once initiated.
- If the implant fails due to patient non-compliance (e.g., smoking), additional charges may apply for replacement.
- Refunds will not be granted once implants are placed.

6. Liability Waiver & Dispute Resolution Clause

- I understand that no outcome can be guaranteed and complications may arise.
- Success depends on biological healing and personal habits.
- Veritas Dental lounge shall not be held liable for failures due to poor oral hygiene, lifestyle, or failure to attend reviews.
- Disputes will be resolved by mediation first; if unresolved, legal action will be governed by Sri Lankan law.

7. Photography & Marketing Consent (Optional)

☐ I consent to the use of my before-and-after photos for educational/marketing purposes (identity not revealed).

☐ I do NOT consent to the use of my treatment photos.

Patient Signature: _____
Date: _____

8. Treatment Plan Details

This section outlines the personalized treatment plan agreed upon between the patient and the dental surgeon.

Treatment Component	Details
Number of Implants Planned	_____
Implant Location(s)	_____
Type/Brand of Implant	
Expected Healing Duration Before Restoration	_____ weeks/months
Type of Final Restoration	☐ Crown ☐ Bridge ☐ Overdenture
Temporary Prosthesis Provided?	☐ Yes ☐ No
Bone Grafting / Sinus Lift Planned?	☐ Yes ☐ No If yes, describe: _____
Number of Surgical Visits Expected	_____
Expected Date for Final Prosthesis Delivery	_____

Treatment Goals:

_____

_____

Additional Notes:

_____

_____

Patient Acknowledgment:
I confirm that the above treatment plan has been explained to me, including timelines, components, and expected outcomes.

Patient Signature: _____ **Date:** _____
Doctor's Signature: _____

10. Warranty Terms & Conditions

Cayo Dental provides a **limited warranty** for dental implants and associated prosthetics under the following conditions:

Warranty Coverage

Component	Warranty Period	Coverage
Dental Implant Fixture (Screw)	5 Years	Free replacement if failure is due to material or surgical defect.
Abutment (Connector)	5 Years	Manufacturing or fit-related failures only.
Crown / Bridge / Over denture	5 Year	Material defects or cementation failure.

Warranty Conditions
To be eligible for warranty claims, the patient must:

- Attend all scheduled follow-up appointments.
- Maintain excellent oral hygiene as advised.
- Avoid smoking, alcohol, and chewing hard substances (ice, betel nut, etc.).
- Report any issues or symptoms promptly.
- Follow all post-treatment care instructions.
- Use night guards if prescribed (especially for bruxism cases).

Warranty Exclusions
This warranty does **not** cover:

- Implant failure due to **patient non-compliance** (e.g., smoking, poor hygiene).
- Damage caused by trauma, accidents, or chewing hard substances.
- Wear-and-tear beyond the normal lifespan of prosthetics.
- Changes due to bone loss or systemic health conditions (e.g., diabetes).
- Failure to attend regular 6-monthly reviews.

Claim Process
In the event of a warranty claim:

- An in-clinic assessment must be carried out.
- Clinical notes and X-rays will be reviewed.
- If the failure meets warranty conditions, Veritas Dental Lounge will repair or replace at no additional charge.

Note: This warranty is non-transferable and only applicable to the original patient treated at Veritas Dental Lounge.

Patient Acknowledgment:
I understand the warranty coverage, conditions, and exclusions provided above and agree to comply with the necessary care requirements to maintain coverage.

Patient Signature: _____ Date: _____
Doctor's Signature: _____