EXCLUSIVE ORAL SURGERY, LLC

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AGREEMENT FOR SHARED RESPONSIBILITY FOR CONTINUING CARE OF IMPLANTS

Patient's Name:_____

Address:_____

_____

Telephone:_____

Name and telephone of alternate person to contact if I am not at the above number:_____

_____

Your diagnosis and treatment includes placement of _____ implants in (list areas)_____

_____

I acknowledge that Dr._____ has advised me of the importance of returning for long-term follow-up which, if not done, may invite chronic infection or other disease of tissues which support my implants, and which could lead to loss of the implant(s) together with any denture, crown or bridge which is supported by them.

I understand that I also must maintain regular maintenance visits with the doctor who placed the dental restorations on the implants, recognizing that abnormal wear or stress on those appliances may also lead directly to implant failure or loss.

I agree to comply with regularly scheduled exams when notified by this office, understanding that I may choose a convenient appointment, but not postpone care beyond a reasonable time. When notified of my appointment, I will call to confirm as soon as possible.

Implants require continuing follow-up, sometimes for years, in order to assure maintenance of bone and soft tissue support.

I also understand that if I feel there are adverse changes in my symptoms or condition between scheduled visits, I should notify this office immediately.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date