

	<h2>INFORMED CONSENT FORM AND FINANCIAL AGREEMENT FOR DENTAL IMPLANT(S) TREATMENT</h2> <p>PUSAT PERGIGIAN U 优牙科中心 U DENTAL CENTER</p> <p>Taman U 大学城: 26A, Jalan Kebudayaan 1, Taman Universiti, 81300 SKUDAI. Tel: 607-521 1111, 607-5208508 SMS: 6012-8800100 HP: 6 014-888 9000</p> <p>Bukit Indah 武吉英达: 65, Jalan Indah 16/12, Taman Bukit Indah, 81200 Johor Bahru. Tel: 07-232 GIGI, 07-232 4444, SMS: 6 014-9 900 900 HP: 6014-888 2000</p> <p>U Dental Specialist Clinic 优牙科专科诊所 Klinik Pakar Pergigian U</p> <p>65A, Jalan Indah 16/12, Taman Bukit Indah, 81200 Johor Bahru, Johor. Tel: 607-234 2000 SMS: 6014-508 0000 HP: 6019-500 6 900</p> <p>www.gigi.my info@gigi.my</p>	
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Instructions to Patient: Please take this document home and read carefully. Note any questions you might have in the area provided (Questions I have to ask my dentist). Bring this back to our office at your next appointment and the doctor will review it with you. You should understand the procedure, the benefits, alternative treatments, and accept the risks (with treatment or without treatment) before signing this form. **PLEASE DO NOT FORGET: ON THE DAY OF THE IMPLANT SURGERY, MAKE SURE THIS COPY HAD BEEN SIGNED AND RETURNED TO THE CLINIC, OR YOUR SURGERY WILL BE POSTPONED AND YOU WILL BE SUBJECTED TO A CANCELLATION FEE.**

Patient's Full Name (hereinafter referred to as "I" or "I/We" or "Patient") As in APPENDIX 3.

Patient's NRIC As in APPENDIX 3.

Clinic/Office's Name (hereinafter referred to as "the clinic"): As in APPENDIX 3, a company incorporated under the laws of Malaysia. The service provider is involved, amongst others in the provision dental and implant treatments and is desirous at the request of the patient/client to provide to the patient/client, dental implant treatments ("the treatment" as hereinafter defined).

Doctor/Dentist's Name (hereinafter referred to as "the doctor") : As in APPENDIX 3.

(including any other agents and such assistants as may be selected by the Doctor)

Form/Document(hereinafter referred to as "this form and/or "I" and/or "this document"): Informed Consent Form And Financial Agreement For Dental Implant(s) Treatment.

I realized that I have the opportunity to discuss with the doctor the planned surgical procedures, the implant system, required prosthetic reconstruction, and my responsibilities postoperatively.

I understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by the doctor.

- ☐ The standard of care requires that the doctor obtain your informed consent before surgery and anesthesia. What you are being asked to sign is simply your acknowledgment that you have been informed about the treatment for your condition and the known risks by conversations with the doctors and staff, printed materials providing such information regarding your treatment, and additional information provided. Please read this form carefully and feel free to ask your doctor about anything you do not understand before signing on the last page.
- ☐ You have the right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the possible risks and hazards, before during or after the treatments. Please be informed of other possible alternative and/or supplemental methods of treatment. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so that you may give your informed consent to the procedure.
- ☐ Please bear in mind that, while the doctor concur that patients have a right to be informed about any treatment, the law requires extensive disclosure of risks of the procedure and anesthesia, many that are extremely unlikely to occur, that can be alarming for the patient. If you wish, please feel free to ask your doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental practitioners.

### General Interpretation and Definition

- Agreement" means the completed "INFORMED CONSENT FORM AND FINANCIAL AGREEMENT FOR DENTAL IMPLANT(S) TREATMENT" (and its attachment(s)) and the terms and conditions herein.
- Variation: Please read the following terms and conditions carefully before you sign up for the dental implant service. By indicating your acceptance of the terms and conditions contained hereof, you are deemed to acknowledge and agree to be bound by all the following terms and conditions for dental implant service

provided by the clinic. The clinic reserves the right to update or revise these terms and conditions from time to time. The clinic may give notice of amendment to the customer in such a manner as the clinic deems appropriate. Continuation in the treatment signifies acceptance of the changes to these terms and conditions with regard to the dental implant treatments.

- In usu juris frequenter uti nos singulari appellatione, am plura significari vellemus. Word and expressions denoting the singular include plural numbers and words and expressions denoting the plural shall include the singular number unless the context otherwise requires.
- Severability: If any section of this document is ruled illegal or invalid, such ruling shall not affect the validity or enforceability of the remainder of the provisions of the document. If at any time any part of this document becomes invalid, illegal or unenforceable in any respect, that invalid, illegal or unenforceable part shall be severed from the remainder of the of the document and the validity, legality and enforceability of the remainder of the document shall not be affected or impaired in any way. Further, the invalid, illegal or unenforceable part will be deemed superseded by a valid, legal or enforceable part that most closely satisfies the intention of the original part. The validity, legality and enforceability of the remainder of the agreement shall not be affected or impaired in any way.
- Entire Contract/Document. No Modifications: This document embodies the whole agreement of the parties. There are no provisos, terms, conditions, or obligations other than those contained herein, and this document shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties hereto. None of the parties has any authority to waive, alter, or enlarge this contract.
- Time of Essence: Time is of the essence in the satisfaction of all terms of the agreements contracted in this document.
- Illustrations, pictures or any graphical representations, are solely artistic impression and may not applied directly to any particular case/patient.
- The expression "him" or any other expressions appear herein shall be deemed to include the masculine, feminine, plural thereof where the context so admits.
- Word denoting natural persons include bodies corporate, partnerships, sole proprietorship, joint ventures and trusts.
- Governing Law : This Agreement shall be governed and construed in accordance with the laws of Malaysia.
- Force Majeure: Neither party shall be liable for any breach of this Agreement arising from cause beyond its control including but not limited to Acts of God, insurrection of civil disorder war or military operations, national or local emergency, acts or omissions of government, highway authority or other competent authority, industrial disputes of any kind (whether or not involving either party's employees), fire, lightning, explosion, flood, subsidence, inclement weather, acts or omissions of persons or bodies for whom neither party is responsible or any other cause whether similar or dissimilar outside either party's control. The parties hereby agree that either party may terminate this Agreement, by giving fourteen (14) days notice to the other party, in the event that the Force Majeure event which has occurred prevents either party from performing and/or continuing its obligations for more than a period of sixty (60) days.
- Compliance with applicable laws: The client shall comply with and not to contravene any and all applicable laws and regulations of Malaysia relating to the dental implant treatment or otherwise, including but not limited to Dental Act 1971 and its subsequent/subsidiary legislations, other Acts of Parliament, local by- laws, rules and regulations issued by relevant government bodies and/or authorities.
- Confidential Information: Except with the prior written consent of the other Party, either Party shall not at any time communicate to any person any confidential information disclosed to him for the purpose of the provision of the dental implant treatment or discovered by him in the course of the provision and performance of the treatment. For the avoidance of doubt, the clinic may disclose any confidential information in regards to this Agreement to its affiliates in its ordinary course of business and/or on need to know basis as the case may be.
- Indemnity: The client undertakes and agrees to indemnify, save and hold harmless the clinic at all times against all actions, claims, proceedings, costs, losses and damages whatsoever including but not limited to libel, slander or infringement of copyright or other intellectual property rights or death, bodily injury or property damage howsoever arising which the clinic may sustain, incur or pay, or as the case may be, which may be brought or established against the clinic by any person including a company or corporation whomsoever arising out of or in connection with or by reason of the operation, provision or use of the treatment and/or equipment under and pursuant to this Agreement and which are attributable to the act, omission or neglect of the client, his servants or agents.

1. PROBLEM LIST IDENTIFIED/COMPLAINED:

After a careful oral examination and study of my dental condition, my doctor has advised me that my condition as below:

- ☐ I have missing tooth/teeth that may be replaced with artificial teeth supported by an implant (*Teeth replacement*)
- ☐ jaw bone loss which could not support retention or stability of prosthesis/denture. (*Improve retention*)
- ☐ Anticipated extraction socket(s) that bone lost can be reduced by putting an implant into the socket. (*Preserve bone from resorption/shrinkage*)

2. PROCEDURE NAME: ENDOSSEOUS DENTAL IMPLANT3. IMPLANT TREATMENTS OBJECTIVE:

I understand that the purpose of this procedure is to treat and hopefully correct my jaw (or the denture/prosthesis supporting areas ) by improving function that has resulted from loss of teeth and bone loss of the jaw(s).

I understand that if this procedure is not performed, progressive loss of the supporting jaw bone may continue, making continued conventional full denture function or later implant reconstruction less satisfactory or even impossible and could lead to spontaneous fracture of my lower jaw.

I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, I could choose is not undergoing surgery or simply continuing to wear a denture. I have also been advised that other alternative treatments done for patients in my condition have included soft tissue vestibuloplasty, grafting the jaw with bone or synthetic materials, and implantation of various types of oral implant devices and I understand and chose to undergo the implant reconstruction that has been described to me.

4. DESCRIPTION OF THE NATURE OF THE PROCEDURE:

Summary: The procedure I choose to treat my condition is Implant, with or without soft/hard tissue reconstruction of the jaw under local anesthesia.

The doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I understand what procedures are necessary to accomplish the placement of the implant(s) either on (subperiosteal), in (endosteal), or through(transosteal) the bone. I understand that the most common types of implants available are **endosteal/endosseous** implant. The implant type recommended for my specific condition is underlined above. I also understand that endosteal implants (more commonly known as root form) generally have the most predictable prognosis.

Surgical phase of Procedure:

I understand that an anesthetic will be administered as part of the treatment. If necessary, my gum tissue will be opened to expose the bone.

Implants will be placed into holes that have been expanded on or drilled into my jawbone. If indicated, the gum and soft tissue will be stitched closed over or around the implants. Healing will be allowed to proceed for two to four months. I understand that dentures/temporary prosthesis must be worn carefully during the first two weeks of the healing phase.

Whenever possible, the doctor prefers one stage implant, i.e. only one surgery to put in the implant. However, some conditions or implants requiring a second surgical procedure, the overlying tissues will be reflected and the stability of the implant will be verified. If the implant appears satisfactory, an attachment(neck), which will protrude through the gum tissue, will be connected to the implant. Procedures to create the implant denture/tooth/teeth replacement can then begin.

5. ALTERNATIVES TO SUGGESTED TREATMENTS/IMPLANTS:

I have considered the following alternatives to implant treatment. Alternative treatment for missing teeth include but not limited to:

- ☐ No treatment. However, continued wearing of ill-fitting and loose removable appliances can result in further damage to the bone and soft tissue of my mouth.
- ☐ Construction of conventional complete or partial denture(s) or maxillofacial prosthesis.
- ☐ Tooth replacements with conventional crown or bridgework supported by my remaining natural teeth (if possible).

Non-treatment risks:

I have further been informed that if no treatment is elected maintain the bone volume or to replace the missing

teeth or existing dentures, the include, but are not limited to:

- ☐ maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but likely, progressive dissolution of the underlying denture-supporting jaw bone;
- ☐ any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time;
- ☐ drifting, tilting and/or extrusion of remaining teeth;
- ☐ looseness of teeth, periodontal disease (gum and bone), possibly followed by extraction(s).
- ☐ a potential jaw joint problem (TMJ) caused by a deficient, collapsed or otherwise improper bite.
- ☐ bone lost after extraction especially within the first 6 months after extraction, after that the bone may be less receptive to an implant (or additional procedure may be needed to 'enlarge' the bone).

I understand the foreseeable risks of those alternatives.

## 6. ADDITIONAL/COMPLEMENTARY PROCEDURES/MODIFICATION

Additional planned procedures include:

- ☐ **BONE GRAFTING** is a surgical procedure that replaces missing bone with material from the patient's own body, an artificial, synthetic, or natural substitute. Bone grafting will be necessary in cases where there is a lack of adequate maxillary or mandibular bone in terms of front to back (lip to tongue) depth or thickness; top to bottom height; and left to right width.
- ☐ Bone graft (autogenous bone, own bone):  
"Ring Technique" invented by DR BERNHARD GIESENHAGEN, Germany": three-dimensional vertical grafts of bone defects and the placement of implant can be carried out in a single surgical procedure with exactly fitted bone ring grafts. The recipient site is prepared and the graft is harvested with trephine drills. The implant site is prepared in the graft before its removal from the donor site allowing rigid fixation when the graft is fixed at the recipient site by the implant. In order to achieve full treatment success, several requirements must be met. Potential intra-oral donor site preparation, including mandibular symphysis (the chin), ramus buccal shelf) and maxillary tuberosity. More bones can be harvested from the iliac crest (pelvic) but hospitalization is required.
- ☐ Bone graft (none autogenous bone): When there is insufficient bone in an area requiring an implant, there will be an additional charge for bone regeneration techniques. The bone may be human or none human origin.
- ☐ Hydroxyapatite: a bone graft.
- ☐ Bone expansion
- ☐ **GUIDED BONE/TISSUE REGENERATION OR AUGMENTATION** (Membrane required): the purpose of treatment is to regenerate bone the jaw, around a natural tooth or around a dental implant. May involve any of the following methods: synthetic augmentation material, bone grafting using demineralized bone, hydroxyapatite grafting (synthetic bone substitute that may be used by itself or in combination with bone ) or my own donor bone.
- ☐ **SINUS ELEVATION/SINUS LIFT** : When the size of the sinus prevents an implant procedure, it must be filled with bone. The operation is planned to implant a bone substitute material, into the floor of the sinus in the hope that new bone will be incorporated into the material so that an implant might be placed. A second procedure may be needed to place the implant(s). It is hoped that the implants will become stable and act as anchors for fixed or fixed detachable bridges or dentures. If the new bone does not incorporate into the synthetic material that alternative prosthetic measures will have to be considered.
- ☐ Osteotome Elevation: Sometimes, when the sinus is large but there is some bone for implant placement, the floor of the sinus can be pushed up with this technique allowing for proper implant placement.
- ☐ Gum recontouring
- ☐ Skin grafting/ vestibuloplasty: a procedure to expose usable bone or grafted material and cover it with a graft.
- ☐ Distraction Osteogenesis: Increase the thickness/height of the bone by modification during bone healing.
- ☐ Other: \_\_\_\_\_

I have also been advised that there is a risk that the implant may break, which may require additional procedures to repair or replace the broken implant.

I authorize the doctor to perform dental services for me, including implants and other relate surgery such as bone augmentation. I agree to the type of anesthesia that the doctor has discussed with me, circled below, and their potential sides effects, specifically local anesthesia injection.

The doctor has also discussed the various kinds and types of bone augmentation material, and I have authorized him/her to select the material which the doctor believes to be the best choice for my implant treatment.

If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or I.V. sedation, I further authorize and direct the doctor/associate/assistant, to do whatever the doctor deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure(s).

I also understand that, during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure other than agreed herein. I therefore authorize and request that the doctor and his associates or assistants under his direction perform such procedure as eventually found necessary and administer such drugs and other treatment as desirable in their professional judgment.

I further understand that if the clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, the doctor will make a professional judgment on the management of the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in the placement, closure and security of my implants.

I further understand that the necessity of my having the bone grafting and other surgical procedures which would be necessary for the placement of root form implants.

I approve any reasonable modifications in design, materials, or surgical procedures, if the doctor's professional judgment decides it is in my best interest to do so.

I agree to any other additional procedures considered necessary in the judgment of my doctor during this operation.

I agree to pay the full charges of additional planned AND/OR modified procedures.

## **6. RISKS AND LIMITATIONS OF IMPLANT TREATMENT:**

I am aware that the practice of dentistry and dental surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the success of my implant treatment, the associated treatment and procedures, or the post surgical dental procedures. I am further aware that there is a risk that the implant placement may fail, which might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.

### **Principal Risks and Complications:**

I understand that some patients do not respond favorably to dental implants, and in such cases, the implant may be lost. Implant surgery may not be successful in providing support for artificial teeth. Because each patient's condition is unique, long-term success may not occur. Complications include but are not limited to:

I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia and related drugs including, but not limited to: failure of the implant (s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. I understand that these complications can occur even if all dental procedures are done properly.

### **SURGICAL/OPERATIVE RISKS**

I have been informed and I understand that there are certain inherent and potential risks and in any surgical treatment or procedure, that such limitations or complications may require additional treatment, and that in this specific procedure the risks of surgery and anesthesia include, but are not limited to:

- ☐ More common side effects of surgery e.g. infection, bruising, disability, swelling, pain, discomfort, facial discoloration, delayed healing, dysfunction of the facial, jaw and neck muscles, limited mouth opening, accidental swallowing of foreign matter.
- ☐ Prolonged or heavy bleeding, formation of a hematoma (blood clot) at the surgery site or in the floor of the mouth and bruising of the chin and lips, any of which may require additional treatment.
- ☐ If the wound become infected, with redness, swelling and discharge, I may need antibiotics to treat this. I may develop a fluid collection under the wound and this may need to be drained. Infection requiring additional treatment or possible removal of the implant. The implant may extrude/exposed. If this occurs the wound is likely to become infected. As with any other foreign material in the body, even if the wound heals normally, my implant may become infected and I may then have to have the implant removed to clear the infection.
- ☐ Stretching, scuffing, cracking or bruising of the corners of the mouth and lips.
- ☐ Injury to adjacent teeth and/or restoration. Transient, but on occasion, permanent increased tooth looseness and/or tooth sensitivity to hot, cold, sweet or acidic foods
- ☐ Trismus: unable to open the mouth to the maximum, for several days.
- ☐ Terminating the surgical procedure due to anticipated lack of sufficient width of bone at the implant sites.
- ☐ Possible injury to sensory nerves of the face and mouth (e.g. inferior dental nerves in the lower jaw bone under the back teeth) or mental nerves near the corner of the mouth) which may cause prolonged temporary - or on occasions permanent - numbness, tingling, or unpleasant sensations of the chin, lip, gum, jaws, face or tongue. Damage (transient or permanent) to the nerve that gives feeling to the lower lip that could result in numbness, tingling, or other sensation in the lower lip.
- ☐ The possibility of temporary, or in very rare occasions permanent, damage to the nerves that control the muscles of the face or decreased function of the facial muscles resulting in some instances loss of facial tone or function.
- ☐ Fracture of the jaw bone which requires further surgical procedures including bone grafts to stabilize the broken jaw. I understand that I must protect my jaw during yawning and avoid chewing forces on the lower jaw during the incorporation phase as discussed.
- ☐ Shrinkage of the gums upon healing resulting in elongation of some teeth and greater spaces between some

teeth

- ☐ There may be an adverse impact to speech
- ☐ Possible nasal/maxillary (nose) sinus or floor of the nose penetration which may need repair.
- ☐ loss of the implant material or device through the mucosa.
- ☐ referred pain to the ear, neck and head.
- ☐ Failure of the implant requiring removal of part or all of the implant at any time after surgery. Loss of one or more implants is possible which could further reduce the minimal amount of existing bone which I now have requiring more extensive bone grafting and other surgical procedures at some future time.
- ☐ Failure may include fracture of components including posts or loss of bone adaptation about the implant at any time following surgery or placement of the denture requiring further surgery to attempt repair or removal of the implant. I understand that failing implants would require removal, and may require additional prosthodontic procedures or the subsequent placement of additional implant(s).
- ☐ change in occlusion (bite)

Prosthodontic Phase of Procedure: During this phase, an implant prosthodontic device will be attached to the implant.

- ☐ Complications around implant posts or screws or fracture of the implant components that require corrective surgery in an attempt to salvage a failing implant may require another incorporation period without the lower denture for at least three months or more to allow proper bony healing.
- ☐ I understand that there will be apparent changes in facial appearance resulting from changes in muscle position. I have been advised and acknowledge that there is no guarantee that the procedure will improve my appearance. Patients react differently depending on several factors including outcome expectations. A good cosmetic result is intended but cannot be guaranteed.
- ☐ Stiffness of the jaw muscles and jaw joints (TMJ) causing prolonged discomfort and/or decreased chewing function. Jaw joint injuries or associated muscle spasm and/or aggravation of an existing temporomandibular joint dysfunction. Pre-existing TMJ symptoms may be worsened especially during the incorporation phase.
- ☐ I understand that the implant is placed through an gum incision on my jaw. Excessive or unsightly scarring is unlikely but possible. If the scar is objectionable, later revision surgery may be desirable.
- ☐ I understand there are risks associated with any anaesthetic. I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation. The exact duration of any complication cannot be determined and may be irreversible, which may require sustained home recuperation, including.

Adverse drug reaction, complications of local, sedative and local anesthetic agents

- ☐ allergic reactions to materials or drugs
- ☐ nausea and vomiting
- ☐ inflammation, infection or bruising at the injection site
- ☐ headache and dizziness
- ☐ life-threatening reactions including heart irregularities, heart attack, stroke, brain damage or death.

#### THE HEAD/NECK OF THE TOOTH/IMPLANT: PROSTHODONTIC OR ESTHETIC RISKS

I understand that prosthodontic risks include, but are not limited to:

- ☐ failure of an implant to osseointegrate (may be immediate or delayed),
- ☐ gum level may less than the adjacent teeth, "black triangle" or lack of gum/papillae around implant, food impaction between crowns.
- ☐ The emergence profile of the crown or the way the crown emerges from the gum may be compromised if the position or gum thickness is not favourable.
- ☐ the crown may be longer than adjacent teeth if the bone/gum is not sufficient
- ☐ compromised esthetic or functional outcome as a result of implant loss or less than ideal angulation/position of the implant,
- ☐ inability to restore or use the implant in the optimal angulation/position/height;
- ☐ Inability to restore or use an implant due to damage to the head of the implant(s) such that it will not allow for proper fit of the restorative components.
- ☐ wear of the restoration requiring remake,
- ☐ fracture of the implant and/or implant components,

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask the doctor if you have any general or specific concerns.

#### INDIVIDUAL OR SPECIFIC RISKS

I understand the following are possible significant risks and complications specific to my individual circumstances, that I have considered in deciding to have this operation:

## Systemic:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Blood disorder
- ☐ Medication
- ☐ Smoking
- ☐ Other: \_\_\_\_\_

## Localized:

- ☐ Reduced bone width
- ☐ Reduced bone height
- ☐ Bone undercut
- ☐ Bone/Tissue Morphology:
- ☐ Factors affecting/compromising the position, angulation or depth of the implant(s):
- ☐ Reduced bone over maxillary sinuses: Risk of perforation or infection of sinuses.
- ☐ Bone graft/augmentation/artificial skin (membrane) may be needed.
- ☐ Reduced bone over Inferior Dental Nerve at the lower jaw: Could not place implant(s) or risk of numbness of corner of the mouth.
- ☐ Unfavorable upper and lower jaw bones relation, e.g upper bone more backwards than lower bone/teeth.
- ☐ Other: \_\_\_\_\_

I acknowledge that I have discussed with the surgeon any significant risks and complications specific to my individual circumstances that I have considered in deciding to have this operation.

*SECOND OPINION:* I prefer to undergo the procedure in the setting and the restriction of a general dental practice. However, upon my written request, the clinic is please to provide to me a non-exhaustive list of dentist or specialist (referred to as the third party). The clinic is no to be held responsible for any interaction between the third party and I.

*TISSUE DISPOSAL:* I agree to the disposal by the clinic of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my clinical records.

*AGREE TO BE TESTED:* If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counseled as soon as practicable after the operation if this has been necessary.

Pre-Operative Care: Reduce Stress(Sedation) and Preparation

It is important that I take regular medications at the regular time, unless otherwise instructed by the doctor.

If I am nervous before the implant treatment, I would ask the doctor to give me some medicines:

- ☐ Sleeping pills: to help me sleep well the nights before treatment.  
I am prohibited to drink alcohol, to drive or operating machinery after taking the medicine.
- ☐ to calm me down 1 -2 hours immediate before the treatment.

If I am taking the medicines mentioned above, I must be accompanied by a responsible adult to fetch me to and from the clinic. The responsible adult should agree to take care of me for the rest of the day.

**7.TREATMENT TIME/INTERVAL:Conventional implant or Mini-implant:**

	<b>STAGES: CONVENTIONAL IMPLANT</b>	<u>Descriptions</u>	<u>Suggested Timing For Oversea Patients/ Tourists</u>
A	Initial examination	<ul style="list-style-type: none"> <li>First Checking/Consultation/Models: 30 minutes</li> <li>Second Checking/ X-ray/case and Agreement Discussion: 15-30 minutes.</li> <li>Optional: Third Checking/Discussion/Consultation: 15-30 minutes</li> </ul>	Day One Morning
B	Implant Site Preparation	Optional Bone graft for cases where bone is not enough, to wait for existing infection to heal etc.	No suitable for short visit tourists
C	Implant insertion	Implant surgery: First implant about 45 minutes, subsequent implant 15 minutes each.	Day One Afternoon
D	Connect Implant with gum healing component or Neck	Prosthetic parts/components (neck and/or head): can be connected to implant IMMEDIATELY OR 2-3 months AFTER surgery, depending to the intended purpose of the implant, the bone quality and individual preference and variations.	Day One Afternoon
	Temporary Crown/Bridge	Plastic Temporary Crown/Bridge	Day One Afternoon
E	Review	Optional Review after surgery: after 1-2 days, 1 week, 1 month, 2 months, 3 months, 6 months.	Day Two Morning
F	Post-operative care	Optional: Take off Stitches (STO), if any: 7-14 days (delayed to 1-2 months if there was bone/gum replacement)	
G	Maintenance	Checking, Scaling/Cleaning every 6-12 months.	At Patient's Home Country or annual visit to Malaysia.

	<b>STAGES: MINI IMPLANT</b>	<u>Descriptions</u>	<u>Suggested Timing For Oversea Patients/Tourists</u>
A	Initial examination	<ul style="list-style-type: none"> <li>First Checking/Consultation/Models: 30 minutes</li> <li>Second Checking/ X-ray/case and Agreement Discussion: 15-30 minutes.</li> <li>Optional: Third Checking/Discussion/Consultation: 15-30 minutes</li> </ul>	Day One Morning
B	Implant Site Preparation	No Necessary	No Necessary
C	Mini Implant insertion	Implant: First and implant about 15 minutes, subsequent implant 15 minutes each.	Day One Afternoon
D	Connect Implant with Patient's existing dentures	Day One Afternoon	Day One Afternoon
	Temporary Denture using	Using Patient's existing dentures	Day One Afternoon
E	Review		Day Two Morning
F	Post-operative care	Optional: Take off Stitches (STO), if any	
G	Maintenance	Checking, Scaling/Cleaning every 6-12 months.	At Patient's Home Country or annual visit to Malaysia.



	STAGES: NEW FULL DENTURE	Descriptions NEW FULL DENTURE is made (not using existing old denture)	Suggested Timing For Oversea Patients/Tourists
A	Initial examination First Model Construction of Special Tray		Day One Morning
B	Biting on Wax 2 <sup>nd</sup> Model (Working Model) Send to set up teeth	Or when the mini-implants are place	Day One Afternoon
C	Trial in wax/sample denture Send to lab convert denture to plastic		Day Two Morning
D	Try in and adjust the plastic denture		Day Three Morning
E	Maintenance	Checking, Scaling/Cleaning every 6-12 months.	At Patient's Home Country or annual visit to Malaysia.
<input type="checkbox"/> Normal time frame to construct dentures= 2 weeks, For expedited laboratory services, 50% Surcharge apply and variable special delivery fee of RM250 chargeable.			

The initial surgical procedure involves making an incision in the soft tissue and exposing the underlying bone. A bone graft or other surgical procedure may be required for the implant placement. Holes are drilled into the bone and the implant(s) will be placed into these holes. The gums are then stitched closed and the area allowed to heal for a variable period of time (2-3 months, or more)

After the healing period, sometimes a second surgical procedure is performed to expose the implant(s) and attach extensions to the implant that will eventually support the restoration. After this second surgery; the prosthodontic phase of my treatment will take place and will involve multiple appointments.

The estimated treatment time could be increased if there is a need for a bone graft or other surgical procedure. Treatment time could also be extended if there are surgical complications. Treatment time could be extended if there is a shortage of hard-to-find materials/parts which needed to be imported.

### 3. NO WARRANTY OR GUARANTEE ON TREATMENT SUCCESS:

Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the best of care. I understand that for implants to be successful they normally must bond directly to bone (called osseointegration). It has been explained to me that implants are not always successful, and that the success or failure of my implant(s) will determine the final design of the restoration(s) placed in my mouth and whether the restoration(s) will be permanently fixed to the implant(s) or will be removable by me. It is understood that although good results are expected no guarantee that it will last for any specific period of time can be or has been given.

No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures.

I hereby acknowledge that no guarantee, warranty or assurance has been given to that the proposed implant treatment will be completely successful or that the final restorations(s) will be totally successful from a functional or esthetic (appearance) standpoint

I understand that implant success is dependent upon a number of variables including, but no limited to: operator experience, individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.

Due to individual patient differences, successes cannot be predicted with certainty. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best of care. No guarantee or warranty of any kind has been made to me. I understand that no medical or dental procedure is totally predictable and that this includes treatment with osseointegrated implants. I understand that because of known or unforeseen factors, further surgical, orthodontic, and/or prosthetic procedures beyond those described to me might be necessary.

I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there exists a risk of failure, relapses, necessity for the retreatment or additional treatment, or

worsening of my condition despite appropriate care. I have been advised that experience with the implant system has shown a long term success rates exceeding 90% for 25 years and more. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long term result and that there will be no refund of fees from the surgeon, restorative dentist, hospital, or the implant manufacturer or distributor in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. Additional expenses may be incurred if corrective procedures are required. I have also been informed that any implant exposed to the oral environment, like teeth, requires meticulous daily oral hygiene and that my failure to comply can in itself lead to failure of the implant. I understand my required postoperative responsibilities including a "no chew" diet and no smoking during the incorporation period of at least three months.

#### POST-OPERATIVE CARE AFTER IMPLANT PROCEDURE:

I understand that medication, drugs, anesthetics and prescriptions may cause drowsiness, impaired physical performance, or lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty four (24) hours after implant treatment or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the

Further, I agree not to operate any motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

I understand that I may have to avoid excessive force when wearing any type of restoration/appliance/denture over the implant site for a period of one to two (1-2) months after the surgery.

#### 4. NECESSARY LONG TERM FOLLOW-UP CARE AND PATIENT'S RESPONSIBILITY OF SELF-CARE:

I understand that there will be several follow-up clinical visits with the doctor the first year following placement of the implant as discussed. In addition I understand that I have the responsibility to personally see the doctor at least once a year for evaluation of implant performance, prosthetic loading of the implant, and oral hygiene.

**TO REVIEW AND MAINTAIN:** I understand that it is important for me to continue to see my doctor. I understand that I am fully responsible for all restorative and non-surgical follow-up care that is provided by the doctor at a cost, and that the doctor will not reimburse me for that treatment and follow-up care done at the other clinic. I was advised to have teeth/implant checked every 6 months and it is my sole responsible to obtain an appointment from the clinic and it is not the clinic's responsibility to remind me regarding my appointment.

**TO KEEP CLEAN:** Implants, natural teeth and prostheses have to be maintained daily in a clean, hygienic manner. Implants and prostheses must also be examined periodically and may need to be adjusted. I understand that it is important to abide by the specific prescriptions and instructions given to me by my treating dentists. I understand that the long-term success of my proposed implant treatment requires that I perform the necessary hygiene and maintenance procedures as directed by the doctor, and that I continue follow-up and recall Appointments. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to the doctor for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will be, at a minimum, a partial cause of implant failure, should that occur. I understand that the more I smoke, the more likely it is that my implant treatment will fail, and I understand and accept that risk.

**RESTRICTED DIET:** I will maintain a "no chew" diet during the implant incorporation phase as discussed and understand that forces on the lower jaw or implant may affect how the bone adapts to the implant.

**NO SMOKING, NO ALCOHOL:** I understand that smoking has been shown to affect the healing of tissues about intraoral implants and appreciate the need to refrain from smoking during the three month incorporation phase of the implant. I have been advised that smoking, alcoholic beverages or sugar consumption may effect tissue healing and may limit the success of the implant. I agree not to use unprescribed drugs and to avoid contact activities, persons with known communicable diseases during the three month incorporation phase.

**TO RE-CHECK:** After initial treatment is complete, the maintenance/follow-up appointments need to be scheduled semiannually or annually. The follow-up care for which I am responsible could include repair or replacement of the implant and/or restoration. This repair or replacement may be needed several times over the years of service of the implant and/or restoration. I understand that implant placement and/or restoration and non-surgical follow-up care of the implant may cost considerably more than a routine restoration (conventional crowns, bridges, dentures, partial dentures, maxillofacial prostheses not involving the use of dental implants) and that the associated expenses are totally my responsibility.

I also agree to cooperate completely with the recommendations of the doctor while under his care, realizing that the lack of such effort could result in complications and a compromised result or failure of the implant.

I promise to, and accept responsibility for failing to, return to this clinic for examinations and any recommended treatment, at least every 6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold the doctor/clinic harmless if my implant(s) fail as a result of my not maintaining an ongoing examination and preventive maintenance routine as stated above

#### 5. TAKING, USING AND KEEPING OF RECORDS AND PHYSICAL ITEMS/MODELS:

I authorize the doctor to take photos, slides, radiographs (x-rays), videotape, (digital or any other) images, models and relevant records of my case and treatment prior to, during and after its completion and may be used in any manner the clinic deems appropriate for the advancement of dentistry, publications, professional examinations and for the marketing and promotional use of the practice and for third party reimbursement/insurance purposes. I give unrestricted use of all of these materials to the doctor, however, no photographs or other records which identify me will be used without my express written consent. I understand that the copyright of the relevant records belong to the clinic but a duplicate record shall be provided to me at a cost.

If a case is terminated/discontinued according to the provisions of this agreement, should the patient wants to take back the models or any physical items, please write in within 14 days of the termination, thereafter all physical (non-electronic) models, template etc will be discarded and the patient agrees that no additional notice/reminder shall be given. Treatment notes and other computerized records shall be kept up to 7 years.

#### 6. PATIENT'S STATEMENTS ON INFORMATION PROVIDED

To my knowledge, I have given an accurate report of my health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, dust; blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I understand that certain mental and/or emotional disorders may contraindicate implant therapy and have therefore expressly circled either YES or NO to indicate whether or not I have had any past treatment or therapy of any kind or type for any mental or emotional condition.

#### Privacy and Personal data Protection Act

The clinic and patient shall observe and adhere to the provisions/guidelines of the privacy and Personal Data Protection Policy which is available on the clinic's notice board, leaflet and website. The patient shall agree that the personal and treatment information shall be provided to third party without prior notice nor consent if it is required by any laws, acts and in exercising any provision(s) in this agreement.

#### 7. TERMINATION

Without prejudice to any other rights or remedies of the parties under this Agreement or at law, either party may terminate this Agreement, in the event:

*Termination by patient:* I acknowledge that I can terminate or change the doctor or clinic anytime I want without prior notice. The refund of deposit, if any, will be depending on the stage of the treatment. Normally the clinic will not charge more than the treatment provided, hence deposit paid is not refundable.

*Termination by default:*

1) The patient agreed that the implant case will be terminated if the patient not be able to start the implant surgery within 3 months after paying deposit.

2) If the patient not agree to the terms and conditions agreed with writing.

3) Mutual termination by patient and doctor.

*Termination by doctor: Termination by doctor is allowed*

1) *if the doctor-patient relation if not conducive for effective carrying out the treatment*

2) *frequent or long term absence from treatment*

3) *lost of contact more than 6 months not be able to contact through telephone, email and mail (address according to patient register provided by the patient)*

4) *Patient refuse or not paying the sum owed.*

I agree that if I do not follow the doctor's recommendations and advice for post-operative care, the doctor may terminate the dentist-patient relationship, requiring me to seek treatment from other dental practitioners. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences that result from not following the doctor's advice.







**8. ATTACHMENTS/APPENDIX:**

- ☐ Appendix 1 and Appendix 2
- ☐ Implant Booklet/Broucher: Bahasa Malaysia, English, Chinese
- ☐ Implant Analysis Forms: English
- ☐ Implant Patient Education: English
- ☐ Implant Patient Information Booklet by the implant's manufacturer

I acknowledge receiving and have read the above documents/attachments. I agree that the above documents/attachments will form part of the information for consent.

**9. Questions I have to ask my dentist**

(Please fill in and use separate sheet of paper in needed)








<p><b><u>Dentsply Ankylos (Germany)</u></b></p> 	<p><b><u>Actual size</u></b></p> 	<p><b><u>NOBELBIOCARE (Switzerland)</u></b></p> 
<p><b><u>Osstem(Korean)</u></b></p> 	<p><b><u>Bicon (USA)</u></b></p> 	<p><b><u>Other Brands: Megagen (Korean), Dentium (Korean), Sybron Direct(USA)</u></b></p> 

**FINANCIAL AGREEMENT**

For the avoidance of doubt, these fees are subject to change without notice and may differ from patient to patient depending upon individual variations and preferences.

**Fees and Payments:** Payment Schedule And Financial Arrangement


The Estimated Cost below is for illustration only.

Procedure: Conventional Implant	Description		ESTIMATED Price Range
Evaluation:  	Model X2 Wax Template: To put on during X-ray X-ray	<input type="checkbox"/>	RM80-100 for 2 models RM50 per piece RM125-150 per DPT or CEPH
	First Consultation		150
	3D x-ray (CBCT) Patient taken 3D 3BCT can <u>apply</u> rebate/ <u>deduction</u> of RM240 (half of RM480 will be reimbursed back to the patient and deducted from the cost of implant deposit) if the patient pay deposit for the implant treatment. within 3 months from the date of taken X-ray.	.	RM480 per 3 Dimensional Cone Beam Computer Tomography (3D CBCT)-multiple slices At Sentosa or Bukit Indah Branch
	Second consultation and trial implantation on 3D X-ray RM150 X2 consultation fee will be reimbursed with patient started implant within 2 months from second consultation.		150
Basic Implant/Root Fee + Placement/Surgical cost	Including local anesthetics, minor consumables, implant root, stitches (if necessary).	<input type="checkbox"/>	<b>RM2900 IMPLANT ROOT ONLY EXCLUDING NECK AND PROSTHESIS.</b>
Optional/if necessary: Bone surgical/graft per dose  Patient's own bone  Skin/Mucosa replacement	Bone Substitutes	<input type="checkbox"/>	RM800 (loose particles) or RM3500-4000 (block graft)
	Bone Substitute -Powder from own extracted tooth (Chin graft or ramus graft)	<input type="checkbox"/>	RM250 per tooth RM900 surgical fee per block/site (1 Donor & 1 Recipient site = 2 sites)
	Artificial membrane or titanium mesh	<input type="checkbox"/>	RM700-900/piece of 10mm x10mm
	Temporary cover the space for the neck when implant is underneath the gum.	<input type="checkbox"/>	RM250-300
Cover screw 		<input type="checkbox"/>	
Gum healing/Sulcus former: 	Forming and supporting the gum when the gum is healing.	<input type="checkbox"/>	RM180-200
Temporary Neck and plastic Crown	<input type="checkbox"/> Per implant <input type="checkbox"/> per provisional crown unit	<input type="checkbox"/>	RM400-600 RM80-100
Neck : Straight, Angled, Ball (For full mouth denture) 	The part that connects the implant and the restoration 	<input type="checkbox"/>	RM1800 Titanium: Standard RM1900-2200 (Titanium: Angulated /Balanced) RM2200-2500 Zirconium Custom Milled/Design: >RM2500 (Individualized)
Head/Crown:	The restoration or "Cap" used to replace a missing tooth or a series of missing teeth.	<input type="checkbox"/>	Basic charge RM980-1250-2500 per conventional crown unit (Hybrid-Porcelain Fused To Metal-Zirconia Full Porcelain)
Laboratory Extra charge 	Gingival mask @ 50 per implant Transfer Abutment: RM150-RM180 Implant Analogue: RM180-200 Implant Model @ 80 Mounting-Standard @ 30 Abutment Modification @ 220 Positioning Key- 50 Palatal Screw for Screw Retained Crown: RM250 High precious alloy RM150-200 per gram (4-6 gram needed per crown unit)	<input type="checkbox"/>	Additional 1200 lab and component charges. RM600 extra per unit crown if high precious alloy is used.
<b>ESTIMATED TOTAL COST</b>	<b>Actual price will be subjected to individual variation, additional procedures/parts/ components.</b>	<input type="checkbox"/>	<b>RM2900 (submerged, without restoration) to RM8000 per IMPLANT AND FUNCTIONING UNIT. If block graft ceiling price RM12000.</b>
Other Services Required  (PLEASE TICK IF YOU NEED IT, CAN BE ARRANGED UPON REQUEST)	Guided Surgical Plate 		RM700 per piece on one implant sleeves/rings, additional RM100 for each implant sleeve.

	<input type="checkbox"/> Translator Service-explain the documents sentence by sentence.	<input type="checkbox"/>	RM200-300 per hour
	<input type="checkbox"/> Accommodation <input type="checkbox"/> Transport <input type="checkbox"/> Other Services	<input type="checkbox"/> <input type="checkbox"/>	Will be quoted upon request Will be quoted upon request Please ask

## Timeline Of Payment Per Unit Implant with Crown (Estimate)

Stages	Charges	Implant Deposit	Crown/Bridge deposit	Other Cost
Appointment Deposit with Specialist/Consultant (None refundable)	RM250			Refundable upon successful implantation
First implant Consultation	RM150			Refundable upon successful implantation
Second Implant Consultation and Simulation Implantation on 3D Xray	RM450	RM1000		Upon acceptance of treatment plan
Day of Implant		RM450		Bone Graft (RM800 per 0.5g), Membrane (> RM800) if any Medicine 35-40 X-ray RM125
Implant Uncover or Final Model		RM1450	RM1250	Gum Former (180-250) X-ray RM100
				Neck (>RM1800)
Issue of Crown			RM1000	
Subtotal		RM2900	RM2250	Minimal without bone graft=2900
Total (Ceiling Price)		Maximum RM8000 (including powder graft, excluding block graft)		

PROCEDURE: IMPLANT	MINI	Description		ESTIMATED Price Range
Evaluation: 		Model X2 Plastic Template: To put on during X-ray	<input type="checkbox"/> <input type="checkbox"/>	RM100 RM50 per piece
		X-ray	<input type="checkbox"/> <input type="checkbox"/>	RM125 per DPT or CEPH RM480 per Cross Sectional Tomogram
Basic Implant/Root Fee + Surgical cost			<input type="checkbox"/>	<b>RM1200-RM1400</b>
Optional: Full upper and lower dentures retained by mini-implants		Acrylic/plastic denture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RM800 for upper OR lower acrylic denture with 12-14 teeth RM1600 for upper AND lower acrylic denture with 12-14 teeth each RM500 additional for metal based denture

Optional: Head/Crown supported by mini-implants	The restoration or "Cap" used to replace a missing tooth or a series of missing teeth.	<input type="checkbox"/>	Basic charge RM750-900 per conventional crown unit
Lab Extra charge	50% surcharge for expedited laboratory services (crown, bridge, denture)	<input type="checkbox"/>	
ESTIMATED TOTAL COST	Actual price will be subjected to individual variation, additional procedures/parts/components.	<input type="checkbox"/>	Per jaw: RM4000-6000 per jaw with full acrylic denture
Other Services Required (PLEASE TICK IF YOU NEED IT)	<input type="checkbox"/> Translator Service-explain the documents sentence by sentence. <input type="checkbox"/> Accommodation <input type="checkbox"/> Transport	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RM200-300 per hour  Will be quoted Will be quoted

## Additional Fees/Options:

## IMPLANTATION PHASE:

- ☐ Intraoral Bone graft- in clinic
- ☐ Major bone graft- in hospital (Patient shall pay all hospital expenses)
- ☐ Bone Regeneration
- ☐ Sinus Elevation
- ☐ Osteotome Elevation
- ☐ Wide Diameter Implant: Wide diameter implants are useful in areas where there is not a lot of bone height or in supporting larger molar teeth.
- ☐ Narrow Diameter Implant: When there is not enough room for a regular diameter implant, a narrow diameter implant is used. Even though this is actually a smaller piece, it is more expensive.
- ☐ Coated Implant: Coated implants are occasionally used in soft bone to promote closer bone adaptation. These implants are more costly.

Special Surface Implant: Like coated implants, these implants are used to promote close bone adaptation in areas where the bone is soft or weak.

## RESTORATIVE PHASE:

- ☐ Overdentures: A removable restoration that attaches to implants. It is made of acrylic resin.
- ☐ Overdenture/metal: Part of the acrylic resin is replaced by metal for greater strength and a thinner restoration.
- ☐ Attachments: Various attachments may be used to anchor overdentures.
- ☐ Bar : A bar might be added to a removable restoration for greater stabilization.
- ☐

**MINIMAL INITIAL DEPOSIT REQUIRED = RM1000 PER IMPLANT PLANNED.****THE REMAINDER SHOULD BE PAID IN FULL IN CASH or by CREDIT CARD, ON THE DAY OF IMPLANT SURGERY.**

Implant price above is for immediate implant, i.e. implantation within 14 days after extraction of a hopeless/compromised tooth, where the bone quantity and quality is still satisfactory. For delayed implantation, i.e. more than 14 days after extraction or on a healed extraction site or non-socketed gum/bone the cost will be more.

I understand that the fee to be paid the doctor includes only the surgical insertion of the implant and that the doctor will make the prosthetic reconstruction at an additional fee charged to me by the doctor for the prosthetic appliance.

I understand that I am financially responsible to the clinic for the entire treatment.

**CANCELLATION / REFUND POLICY:**

Cancellations and/or reductions on or within 3 days (72 hours) after deposit payment will be eligible for a refund of 50% of the **initial deposit required**. Cancellations and/or reductions after 3 days of deposit payment will not be eligible for any refund. If the appointment you chosen is within 72 hours from the day you paid your deposit, no request for refund will be entertained.

**CHARGES FOR CANCELLED, LATE OR CHANGED APPOINTMENT:** If the patient cancel or change an implant surgery appointment without **12 hours** prior notice, a setup charge (including equipments, instruments and nursing cost) of **RM300 (Ringgit Malaysia three hundred)** is chargeable and if applicable, deductible from the deposit paid. You are advised to plan your trip to the clinic on the day of implant surgery and please come at least 30 minutes in advance before the actual appointment time. No excuses (e.g. flight delayed, immigration/custom congestion, vehicle breakdown, weather, parking problem etc.) will be accepted for your lateness to attend the clinic. If you do not attend

10 minutes AFTER your appointment time, you are deemed to cancel the appointment. In such situation that your are late and not starting the implant surgery on time, the doctor may advise you to schedule for another day in order to maintain the quality of treatment, if your late treatment affects the quality of care to you or other patients.

**DEPOSIT NO REFUND AFTER 90 DAYS:** After the patient sure to undergo the implant treatment, the patient is required to pay **Initial minimal deposit required** so that the clinic can start the preparation. The patient promised to start the treatment within 3 months. After 3 months from the payment of deposit, **if the patient still not be able to commence the treatment consented**, the patient agree that the deposit will be forfeited and any excuse will not be considered, unless the patient can submit a medical report that the patient is suffering critical illness not suitable for dental implant or during the said 3 months period the patient is hospitalized for more than 60 days (Deposit minus applicable expenses will be refunded if patient no longer medically fit to undergo implant treatment.) If the patient requested to terminate the case then doctor/clinic will not owe the patient any duty of care.

**EXCLUSIONS:** The patient understand and acceptable to the fees being charged, The fees includes NO additional postoperative x-rays, injections, or anesthetics that may later be necessary to correct any complications. Pre-implantation assessment, preparation, new prosthesis, dentures, metal denture or crowns/bridges are not included in the implant charges:

I understand that any surgical procedures to correct complications required within three months following the date of the initial surgery will be performed by the doctor at no additional charge. However, I understand that after three months following the initial surgery, any surgical procedures required to correct any complications or to remove and/or replace part or all of the implant will be paid by me to the doctor at the usual fee charged at the time such services may be needed.

**FAIR TRADE PRACTICE:** Without contrary to any clauses in this document, a refund (Please fill in and sign Appendix 2 for a refund) RM400-RM900 will be pay back to the patient if an implant (mini-implant or conventional implant respectively) failed to integrate into the bone after 3 months of implantation, but replacement of failed implant, bone/gum augmentation or any other remedial procedure(s) are not included in the cost.

**VALIDITY OF THE PRICE/QUOTATION:** The price quoted is valid for 30 days, after which a new price estimation or quotation is necessary. If the treatment involved multiple implants or span more than 12 months, prices will be base of the prevailing price list displayed at the clinic.

#### Warranties and Acknowledgement:

By Signing on the Appendix 3 of this FORM, I FURTHER CERTIFY AND HEREBY WARRANTS THAT:

- ☐ I have had an opportunity to read and fully understand the terms and words within the above consent and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before i signed.
- ☐ if the client is a body corporate, it has the required corporate authority to enter, execute and be bound by the terms and conditions of this Agreement.
- ☐ I has the legal capacity to enter into this Agreement and is not a minor;
- ☐ I understand and agree that my initial on each page along with my signature below will be considered conclusive proof that I have read and understand everything contained in this document. I have had an opportunity to take this form home and had to read and fully understand this form before signing it.
- ☐ I have my questions discussed and fully answered . The doctor answered my specific queries and concerns to my satisfaction.
- ☐ I understand English OR this document was explained in the language that I could fully understand the terms and words within this document and related documents, and that all blanks were filled in where applicable.
- ☐ My signature below signifies that I understand the surgery and anesthetic that is proposed to me together with the known risks and complications associated.
- ☐ I have been given sufficient information and I hereby give my informed consent to proceed with the placement of implants, related surgery (including any ancillary bone grafting)and the associated prosthetic procedures for restoring the implants.
- ☐ I accept all the possible risks, the terms and conditions stated in this document.
- ☐ I have received a copy of this form to take home with me.



**INFORMED CONSENT FORM AND FINANCIAL AGREEMENT FOR DENTAL IMPLANT(S) TREATMENT**  
**PUSAT PERGIGIAN U 优牙科中心 U DENTAL**

**Attachments International Presents**  
**Dental Flash - Case Design**

dentist : DR. LEONG CHEE SAN  
lab : Malaysian Dental Corporati  
patient : DEMO ONLY  
created : 13:52 , 5/14/2008  
last saved : Not saved  
comments :

**Sample Radiograph:**



Date	Doctor	Additional Notes:	Patient's Signature

**APPENDIX 1: DESCRIPTIONS AND COMPARISONS****CATEGORIES: CONVENTIONAL/STANDARD VS. SMALLER DIAMETER MINI (TRANSITIONAL) IMPLANTS**

	Conventional/Standard: Endosseous Root Form Implants	Mini (Transitional) Implants
Description	These are the implants that were originally designed by Dr. P. I. Brånemark in Sweden. They are cylindrical in shape and are inserted into bone in a specific manner.	Narrow diameter implant usually around 2mm in diameter (standard implants are about 4 mm in diameter). They were initially designed as temporary implants to hold a restoration in place while normal implants were healing. They have now become an entity unto themselves and are used by some dentists in many different short and long term situations.
Surgical Advantages/Disadvantages	<ul style="list-style-type: none"> <li><input type="checkbox"/> Endosseous implants are basically cylinders (with or without threads) and as such require a cylindrical osteotome (a round hole) to place them making them the easiest implants of all to place consistently. Since they approximate the general size of a normal tooth root. They can easily be placed in sites where roots existed making them very versatile for replacing one or more teeth. Installation is very consistent across the group of implants in this category often allowing the dentist to simplify the armamentarium. These implants may be straight sided or tapered.</li> <li><input type="checkbox"/> The surgery requires a rather high level of training and sophisticated approach towards manipulating bone and soft tissues. While this is not a disadvantage per se, it is an indication that placement of endosseous root form implants requires and a total regard for the hard and soft tissues in the area</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> They can be easily placed, usually without the necessity of surgery or raising a flap (cutting into the tissue/skin).</li> <li><input type="checkbox"/> Best indicated for anterior mandible, but may be used in any areas of the mouth where there is sufficient bone height (10mm or more).</li> </ul>
Prosthetic Advantages/Disadvantages	<ul style="list-style-type: none"> <li><input type="checkbox"/> The basic cylindrical shape is also very conducive to attaching a single tooth restoration while still allowing for the placement of bridges and overdenture restorations in multiple situations. The ability to precisely locate the implant in the position occupied by a root is also a tremendous advantage in prosthetic reconstruction.</li> <li><input type="checkbox"/> Placement of implants in poor position relative to the tooth location will be difficult to correct. Present technique can only specify to place the implants in ideal position. Basically poor technique is poor technique, but these systems have very little tolerance for poor technique.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Good for stabilization of mandibular overdentures or in areas of tooth replacement that are too narrow for conventional endosseous implants.</li> <li><input type="checkbox"/> Limited prosthetic application and the inability to modify future restorations.</li> </ul>
Economics	These implants are easy and economical to manufacture. They can be made anywhere around the world and titanium is the most Abundant metal we have. Manufacturers add on quite a bit and then dentists add on even much more, but considering the service, they are cost effective.	Economic and may be used in situations where the cost of conventional endosseous implants are prohibitive.
Recommendations	Endosseous root form implant is the standard for dentistry today.	Best suited for mandibular overdenture restorations.

**IMPLANTATION: IMMEDIATE VS DELAYED AFTER EXTRACTION**

	IMMEDIATE	DELAYED
Description	Put in implant immediately after extraction or before socket healed.	Put in implant after extraction socket healed.
Advantages	If done on the same day, no additional injection or surgery needed other than that for extraction. Drilling is less or not necessary at all.	Final level of bone is seen before surgery
Disadvantages	Final level of bone is not predictable accurately. Implant may not same level with bone. May need bone graft. No suitable if there is infection. May need to delay 1-2 weeks before putting the implant.	Has to drill or modify the bone.

**TECHNIQUES: HOW MANY SURGERIES**

	ONE STAGE	TWO STAGE
Description	Placement of implant with one surgical procedure.	Implant is surgically placed and covered over with the gum tissue. Two to four months later, the gum tissue is opened and a second piece is screwed into the implant to allow the soft tissue to heal around the site. The teeth can then be made or attached.
Advantages	There is no need for an additional surgery.  Can be put in immediate function.	The implant remains protected throughout healing. More change to contour the gum to better thickness
Disadvantages	Modification of temporary or permanent restoration may be needed after wound/gum healed.	Requires a second surgery. Additional time is necessary for healing from the second stage surgery.

**LOADING: CONNECT IMPLANT TO FUNCTIONING UNITS**

	IMMEDIATE LOADING	DELAYED LOADING
Description	After surgery immediate connect the implant to function e.g. crown/bridge/denture	The implant is left undisturbed, usually under the gum, for 2-4 months. After that it is connected to denture/crown/bridge.
Advantages	No waiting time for placing the restoration in function. Save time. Good for front teeth where beauty is a concern in social occasions.	Ensure implant is stable before put it into function. Disadvantage: May need a temporary denture/prosthesis/bridge.
Disadvantages	Higher failure rate.	Has to wait 2-4 months before final restoration. Temporary prosthesis may not be as good as the final prosthesis.

Instruction to patient: PLEASE DO NOT sign this form unless your implant failed to join the bone after 3-6 months of insertion.

**APPENDIX 2: RELEASE FORM/Refund Request****Full and Final Settlement**

In consideration of the payment to \_\_\_\_\_ (NRIC: \_\_\_\_\_) of the sum of Ringgit Malaysia(RM \_\_\_\_\_), and other good and valuable consideration. I, being of lawful age, have released and discharged, and for my heirs, executors, administrators and assigns release and forever discharge U Dental Center and any other person, and his/her/their successors, assigns, heirs, executors, and administrators from any and all actions, claims of action or demands for damages, costs, loss of use, loss of services, expenses, compensation, consequential damage or any other thing whatsoever, on account of or in any way growing out of any known or unknown personal injuries, death or property damage resulting or to result from an occurrence, treatment, or lack thereof, by the doctor, his/her agents, employees, independent contractors, or professional corporation, and which occurrence, treatment or lack thereof spanned a period of time from approximately \_\_\_\_\_ from date of the

- i) "Informed Consent Form And Financial Agreement For Dental Implant(S) Treatment Form" to the date of this "RELEASE FORM".
- ii) Other treatments:-  
Ortho(s)/Crown(s)/Bridge(s)/Veneer(s) \_\_\_\_\_

I hereby acknowledge and assume all risk that the said injuries or damages may be or become permanent, progressive, or more extensive than is now known or expected. No promise or inducement which is not expressed in this agreement has been made to me and, in executing this release, I do not rely on any statement or representation made by any person, firm, or corporation hereby released, or any agent, physician, dentist or any other person representing any of them, concerning the nature, extent or duration of said damages or losses or the legal liability therefore.

I understand that this settlement is the compromise of a doubtful and disputed claim, and that the payment or forgiveness of payment or debt owed is not to be construed as an admission of liability on the part of the persons, firms and corporations hereby released and by whom liability is expressly denied.

This release contains the ENTIRE AGREEMENT between the parties and the terms of this release are contractual and not a mere recital. The parties hereby acknowledge that this release and payment hereunder are not being made as a result of any written claim or demand.

I here by accept payment method as below:

Cash

Direct Transfer to Account Number: \_\_\_\_\_ Bank: \_\_\_\_\_

Cheque number ; \_\_\_\_\_ Cheque Date: \_\_\_\_\_ Bank: \_\_\_\_\_

I have carefully read the foregoing release and understand the contents thereof, and I sign as my own free act.

This Release Form dated: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

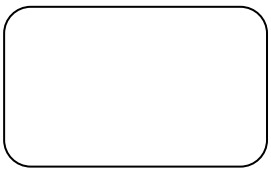


\_\_\_\_\_  
Guardian (Admitted) Name, Signature and Date

If the patient is less than 21 years of age or an adult that unable to give consent.

Clinic Authorized Signature

U DENTAL CENTER/ U DENTAL SPECIALIST CLINIC

**APPENDIX 4: INFORMED CONSENT FORM AND FINANCIAL AGREEMENT FOR DENTAL IMPLANT(S) TREATMENT**

PATIENT'S REGISTRATION NUMBER: DATE OF THIS FORM GIVEN TO PATIENT:	RN: NRIC/Passport:  Age:  Date:	
Patient's Full Name: Patient's NRIC:	Signature: X Signature Date:	
Chinese Name (if any): Christian Name (if any):		
Patient's Address Patient's Telephone Number		
Guardian of the Patient (Required if the patient is less than 21 years of age or an adult that unable to give consent.) Full Name: NRIC: Relationship to Patient:	Signature: X Date: (Admitted: I declare that I am the rightful guardian and have the legal authority to sign this on behalf of the above named patient)	
Clinic/Office's Name and Address   	<p align="center"><b>PUSAT PERGIGIAN U</b>          优牙科中心  <b>U DENTAL CENTER</b></p> <p align="center"><b>Operated By :</b>  <b>TAMAN U DENTAL SURGERY SDN. BHD.(612418-V)</b></p> <p><input type="checkbox"/> <b>Taman U 大学城 :</b>          26A, Jalan Kebudayaan 1,          Taman Universiti, 81300 SKUDAI.          Tel/Fax:607-521 1111, 607-5208508.          SMS: 6014-888 9000</p> <p><input type="checkbox"/> <b>U DENTAL SPECIALIST CLINIC</b>          优牙科专科诊所  <b>KLINIK PAKAR PERGIGIAN U</b>          65A, Jalan Indah 16/12, Taman Bukit Indah,          81200 Johor Bahru.          Tel: 607-234 2000 SMS: 6019-500 6 900 HP: 6014-508 0000</p> <p><input type="checkbox"/> <b>Bukit Indah 武吉英达:</b>          65, Jalan Indah 16/12,          Taman Bukit Indah,          81200 Johor Bahru.          Tel: 07-232 GIGI, 07-232 4444,          SMS:6 014-9 900 900 HP: 6014-888 2000</p>	
Doctor in charge/Dentist's Name	<input type="checkbox"/> Dr. Leong Chee San BDS(Malaya), MFGDP(UK), MCLinDent(Prosthodontics) (London), MFDS RCS(Edinburgh), AM(Mal), PG. Dip. Implant (UCLAN), FICDDE National Specialists Register No: 128515  <input type="checkbox"/> Dr. Sundrarajan Naidu Ramasamy DDS(UKM), MCLinDent(Oral & Maxillofacial Surgery)(UM),AM	
DECLARATION BY THE DOCTOR: I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient. I have given the patient an opportunity to ask questions and I have answered these.	Doctor/Dentist: Signature: Date:  Witness's Name: Signature: Date:	

INTERPRETER'S DECLARATION: (Optional) I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor.	Interpreter's Name Signature Date:
--	--

For Office Use Only: Patient's Preferences:			Notes
1.)	3D-xray (3D CBCT) Indicated:  Template Needed/Ready  Referral/Location of X-ray Facility:	Date:  Date:	
2.)	Copy of X-ray Received:	Date:	Signature of Staff:
3.)	Bone/Gum Augmentation Preference		
4.)	Usual days for appointments		
5.)	Having other dentists/panel to perform general dentistry.		
6.)	Agreement copy received by patient:	Date:	Patient's Signature:
7.)	Models taken by patient: _____ Models	Date:	Patient's Signature:
8.)	Misc.		



For Office Use Only

IMPLANT CONSULTATION SET (EN/BM/Ch)	Languages			Prepare By: Date:	Given to pt: Date:
Implant Agreement (EN)	EN	-	-	<input type="checkbox"/>	<input type="checkbox"/>
Implant paper	EN	BM	CH	<input type="checkbox"/>	<input type="checkbox"/>
Missing teeth paper	EN	BM	CH	<input type="checkbox"/>	<input type="checkbox"/>
Implant Book-Photocopy	EN	BM	CH	<input type="checkbox"/>	<input type="checkbox"/>
Implant Leaflet-Colour	EN	-	-	<input type="checkbox"/>	<input type="checkbox"/>
X-ray Referral Form	EN	BM	CH	<input type="checkbox"/>	<input type="checkbox"/>
Privilege Leaflet	EN	-	-	<input type="checkbox"/>	<input type="checkbox"/>
Referral Cards x2	EN	-	-	<input type="checkbox"/>	<input type="checkbox"/>
Other:.....				<input type="checkbox"/>	<input type="checkbox"/>
				Staff Initials:	Staff Initials:

The Following page is a return page to the patient after the patient submitted the signed copy of the agreement. A photocopy shall be given to the patient  
 Clinic Copy of Agreement Return Acknowledgement


Patient's Name:	
Registration Number	



This page is intentionally left blank.

&lt;DETACH HERE&gt;-----

Patient Copy of Agreement Return Acknowledgement

Patient's Name:	
Registration Number	

IF YOU RETURN A SIGNED COPY OF THIS AGREEMENT PLEASE GET A SIGNATURE FROM THE ATTENDING STAFF: PLEASE GET AND KEEP THIS SLIP AS THE PROOF:

ACKNOWLEDGMENT RECEIVED COPY OF ORIGINAL AGREEMENT RETURNED BY PATIENT:

STAFF NAME:

DATE:

STAFF SIGNATURE: