Indident
DENTAL IMPLANT

Patient Data Sheet

- Name of the Centre :
- Address of the Centre :
- Name of the Operator :

Patient Record Form

- **Serial No :**
- **Regn No /OPD No :**
- **Patient's Name :**
- **Age / Sex :**
- **Religion :**
- **Occupation :**
- **Veg/Non veg :**
- **Habits :**
- **Hobbies :**
- **Postal Address :**
- **Tel No**
  - **Office :**
  - **Residence :**

CONSENT TO DENTAL PROCEDURES INCLUDING SURGERIES

1. I authorize the performance upon _____ the following procedure (s) _____ to be performed under the direction of Dr. _____.

2. The Doctor has fully explained to me the kind of procedure he/she will perform and has answers my questions about my condition and procedure. And I understand the risks and am willing to undergo the procedure. This I consent to of my own free act and will.
3. The doctor has also explained other methods of treatment to me and I have decided to undergo this above mentioned procedure, including the administration of blood products, general/local anaesthesia if necessary, as the best means of trying to correct my condition.
4. I understand that during the course of this procedure, the doctor may find other unhealthy conditions in me that may need correction. I therefore also authorize the doctor to perform such procedures which he/she may find necessary to do in order to improve or correct these conditions after informing me.
5. Doctor has also explained that, in performing the procedures he/she may use assistants, hygienist, or other doctors and nurses and he/she has my consent to do so.
6. No guarantee has been given to me by my doctor about the results of the procedure, and I also understand that there are times when more than one procedures may be necessary to complete the treatment of my condition.
7. I consent to observing, photographing or televisioning of the procedure, to be performed, including appropriate portions of my body, for medical, scientific or educational purposes provided my identity is not revealed by the pictures or any descriptive text accompanying them.
8. I consent to the disposal by the authorities of any tissues or part that may be removed during the procedure.
9. I also agree to cooperate fully with my doctor and to follow, to the best of my ability, his/her instructions and recommendations about my care and treatment.

Witnessed by: Patient's Signature:

_____ _____

Date:

Release Consent
I am satisfied with the treatment given to me.

Signature of Patient

GENERAL CONDITIONS & BRIEF DESCRIPTION OF THE PATIENT

- **Patient's Name**

- **Chief Complaint of the patient**

- **Brief Clinical History**

- **Past Treatment History**

PATIENT EXAMINATION

❖ EXTRAORAL EXAMINATION:

❖ INTRAORAL EXAMINATION

State of Edentulousness
(Kennedy's Classification)

- ❖ **Class I : Yes /No**
- ❖ **Class II : Yes /No**
- ❖ **Class III : Yes /No**
- ❖ **Class IV : Yes /No**
- ❖ **Edentulous Maxilla : Yes /No**
- ❖ **Edentulous Mandible : Yes /No**
- ❖ **Both Jaws Edentulous : Yes /No**

Relationship of Jaws

- ❖ **Class I : Normal**
- ❖ **Class II : Retrognathism**
- ❖ **Class III : Prognathism**
- ❖ **Close Bite :**
- ❖ **Open Bite :**
- ❖ **Deep Bite :**
- ❖ **Others if any :**
- ❖ **Inter-arch Distance : mm**

RADIOLOGICAL EXAMINATION

1. **Intra – oral**

2. **Extra- oral**

3. **OPG**

- **Pre-operative**

- **Immediately Post –Op After 7 days**

- **6-8 weeks after loading the Implant**

3. **CT**

SUFFERING FROM ANY SYSTEMIC DISEASE

- ❖ H/o Diabetes Mallitus :
- ❖ H/o Exposure to Radiation :
- ❖ H/o Hypertension :
- ❖ H/o Fracture or Surgical Intervention of Jaws :
- ❖ H/o Blood Dyscrasias :
- ❖ H/o Cardiac Abnormalities :
- ❖ H/o Any Drugs Intake :
- ❖ H/o Any Neural Disorder :
- ❖ H/o Any other Disability / Disorder :

PRE OPERATIVE EVALUATION / FINDINGS

- Nature of the Mucosa :
- Nature of the Alveolar Bone :
- Available Bone **Height** :
  - Maxilla
    - (a) Anterior
    - (b) Posterior
  - Mandible
    - (a) Anterior
    - (b) Posterior
- Available Bone **Width** :
  - Maxilla
    - (a) Anterior
    - (b) Posterior
  - Mandible
    - (a) Anterior
    - (b) Posterior
- Relationship of Anatomical Structures:
  - (a) Maxillary Sinus
  - (b) Inferior Alveolar Nerve
  - (c) Mental Foramina
- Pre Implant Surgical Procedure , if any:
  - (a) Vestibuloplasty
  - (b) Oral Prophylaxis
- Mouth Preparations :
- Any Other Treatment :

TREATMENT PLAN

- **Implant Selection**

(a) No of Implants Placed:

(b) Size / Diameter of the Implant

3.8mm Dia
4.2mm Dia

(c) Length of the Implant
8mm
10mm
12mm

(d) Splint Design

(e) Surgical Procedure of Implants

(f) Post Operative Findings

- ❖ After 7-10 Days
- ❖ After 4 weeks
- ❖ After 8 weeks
- ❖ After 12 weeks

FOLLOW UP

	1-1/2 months	3 months	6 months	9 months	12 months
Radiological Evaluation:					
Vertical Bone Loss :					
Presence/ Absence of Radiolucency :					
state of Osseointegration :					
Mobility of Implant :					
State of masticatory Efficiency :					
Intraoral Radiographs :					
Gingival Health :					
Suppuration index :					
Plaque index :					
Calculus Index :					
Bleeding index :					
Inflammatory state					
Patients comment Regarding Comfort and satisfaction :					
Esthetics :					
Discoloration of Mucosa around Implant :					

Criteria for success

1. Zero mobility
2. Not> 0.2 mm vertical bone loss annualy
3. Absence of Radiolucency around Implant

PROSTHETIC REHABILITATION

1) Temporary restoration : Acrylic

2) Permanent Superstructure :
Crown : Ceramic :
Bridge

Cantilever Bridge : Not > 10mm in maxilla
Not > 20 mm in mandible

Bar attachment : Ball & Socket Variables not to be
Snap on attachment included

Removable overdenture : On lay dentures

Alloy used for Superstructure : Cr – Co alloy (*wherever applicable*)

	1-1/2 months	3 months	6 months	9 months	12 months
Overall patient satisfaction :					

Signature of Prosthodontist **Signature of Oral Surgeon**

Institution /Clinic :

Date :