



DEPARTMENT OF THE NAVY  
NAVAL DENTAL CENTER SOUTHWEST  
2310 CRAVEN ST.  
SAN DIEGO, CALIFORNIA 92136-5596

NDCSWINST 6670.4D  
01PRS  
23 Jun 04

NAVDENCEN SOUTHWEST INSTRUCTION 6670.4D

Subj: THE USE OF DENTAL IMPLANTS

Ref: (a) BUMEDINST 6320.82 CH-2 of 16 Dec 94  
(b) BUMED ltr 6600 M3D32/01083 of 12 Dec 03  
(c) NDCSWINST 6320.3

Encl: (1) Dental Implant Program Protocol  
(2) Dental Implant Patient Treatment Plan and Treatment Policy  
(3) Informed Consent for the Placement and Restoration of Osseointegrated Dental Implants  
(4) Dental Implant Complication Report

1. Purpose. To provide guidance for the use of dental implants at Naval Dental Center Southwest (NDCSW) southern clinics per references (a) through (c).

2. Cancellation. NAVDENCENS DIEGOINST 6670.4C.

3. Policy

a. The Commanding Officer shall designate a staff prosthodontist, privileged in the restoration of dental implants, as the Command Coordinator/Consultant for Dental Implants. The Commanding Officer will be the privileging authority for the placement, restoration and/or maintenance of implants. He will also approve membership of command Dental Implant Boards.

b. Each dental region of NDCSW that has providers credentialed in the placement and restoration of dental implants and who wish to provide that treatment option, will establish a Dental Implant Board (DIB).

c. Each Dental Implant Board will establish its own dental implant protocol program using this instruction and enclosure (1) as a guide.

d. Each Dental Implant Board will be responsible for purchasing, ordering, maintaining and tracking its own implant supply inventory, and keeping an up-to-date patient tracking system and database. These can be computerized and/or written.

4. Action

a. The Command Coordinator/Consultant for Dental Implants will:

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(1) Serve as Chair, Command Dental Implant Board, southern branch dental clinics, and oversee the implementation of the Dental Implant Program Protocol, enclosure (1), and ensure patient data collection utilizing enclosures (2) through (4).

(2) Nominate staff members privileged in dental implant treatment from the command's Prosthodontics, Periodontics, Oral and Maxillofacial Surgery, Operative and Comprehensive Dentistry trained communities as members of the Dental Implant Board.

(3) Designate an oral maxillofacial surgeon or periodontist, who is a member of the Dental Implant Board, to act as custodian of surgical implant equipment, instrumentation, and components.

(4) Review all implant treatment plans formulated by staff personnel.

(5) Purchase all surgical and restorative implant equipment, instrumentation and components used to treat implant patients.

(6) Recommend clinical requirements for the surgical and restorative aspects of dental implant treatment.

(7) Ensure all implant patients have a surgeon and a restorative dentist privileged in dental implant treatment on their treatment team, and that the Dental Implant Board approves the patients before any implants are placed.

(8) Act as custodian of prosthetic equipment, instrumentation, and components used in the restoration of implants. Maintain a restorative instrument pack and a selection of prosthetic components for issue in facilitating restorative procedures performed at southern branch dental clinics.

(9) Maintain minutes of the Dental Implant Board meetings and submit them to the Director for Clinical Services for review and approval.

(10) Collect and maintain patient data, which includes but may not be limited to, the Dental Implant Board's approval, disapproval or decision to decline care; location of fixture sites; date of placement, uncovering, and completion; number of fixtures and components utilized throughout treatment; and complications/failures. Data will be kept while the patient is undergoing treatment, transfers out of the San Diego area, or leaves the military service.

(11) Ensure that any patient who has an Advanced Clinical Program (ACP)/Advanced Education in General Dentistry (AEGD) student as part of the team receives continuity of care between classes of students.

(12) Advise the Commanding Officer on matters pertaining to the Command Dental Implant Program.

b. The Surgical Implant Equipment, Instrumentation, and Components Custodian will:

(1) Act as a liaison and point of contact to the Command Coordinator/Consultant for Dental Implants in maintaining and requisitioning surgical equipment, instrumentation, and components. Maintain an accurate inventory of surgical components, equipment, and instrumentation. Request all new purchases through the Command Coordinator/Consultant for Dental Implants. Provide dental implant related components and materials to surgical providers.

(2) Maintain a selection of surgical components/instrumentation for issue in facilitating surgical procedures used in the placement of dental implants.

(3) Act as custodian of surgical equipment, instrumentation, and components used in the placement and uncovering of implants.

c. The Restorative Provider will:

(1) Hold clinical privileges in the restoration and maintenance of dental implants.

(2) Be responsible for coordinating surgical and restorative treatment plans.

(3) Be responsible for the fabrication of any necessary surgical guides following consultation with the surgeon.

(4) Ensure the completion of the "Patient Treatment Plan and Treatment Policy," enclosure (2), and be able to present the patient to the Dental Implant Board utilizing this form.

(5) Ensure the patient properly completes the "Informed Consent for the Placement and Restoration of Dental Implants," enclosure (3).

(6) Be responsible for the completion of restorative aspects of the dental implant treatment plan.

(7) Complete and forward "Dental Implant Complication Report," enclosure (4), to the Command Coordinator/Consultant for Dental Implants whenever a complication is encountered that significantly alters the treatment sequence or outcome.

(8) Notify the Command Coordinator/Consultant for Dental Implants of any implant components utilized or required, and the date of final restoration placement.

(9) Forward any components required for the fabrication of the implant restoration to the Area Dental Laboratory.

d. The Surgical Provider will:

- (1) Hold clinical privileges in the surgical placement and maintenance of dental implants.
- (2) Assist in the completion of the "Patient Treatment Plan and Treatment Policy," enclosure (2), and be able to present the patient to the Dental Implant Board utilizing this form.
- (3) Be responsible for the completion of surgical aspects of the dental implant treatment plan and the notification of the Command Coordinator/Consultant for Dental Implants of dates of Stage I and II surgeries, associated grafting, and fixtures utilized.
- (4) Notify the Custodian of Surgical Implant Equipment, Instrumentation, and Components of any implant components utilized or required.
- (5) Complete and forward the "Dental Implant Complication Report," enclosure (4), to the Command Coordinator/Consultant for Dental Implants whenever a complication is encountered which significantly alters the treatment sequence or outcome.

e. The Area Dental Laboratory will offer primary support in the fabrication of implant restorations for branch clinics.

5. Actions. Dental implant providers will adhere to the requirements of the Dental Implant Program, enclosure (1), in the selection, treatment, and follow-up of patients. Specific actions related to the overall management of the Dental Implant Program are:

a. A Prosthodontist, privileged in the restoration of dental implants, will chair the Dental Implant Board. If one is not available at a remote clinic, then the parent command implant board should review the case. Members of the DIB, at a minimum, must also include a privileged staff Oral and Maxillofacial Surgeon and/or a Periodontist. Dental officers privileged in dental implants from Prosthodontics, Periodontics, and Oral and Maxillofacial Surgery Departments, as well as privileged staff Operative and Comprehensive-Trained Dental officers, may serve on the DIB as ad hoc members.

b. The DIB will evaluate all patients to be considered for dental implant therapy and will follow the protocol as outlined in enclosure (1).

c. Implants must be commercially pure titanium metal with an internal connection or an external hex implant-abutment mating surface. Restorative components and equipment must be compatible with the Nobel Biocare and/or 3i systems. Purchase of any other dental implant system requires approval by the Specialty Leader for Dental Implantology.

d. Prior to initiation of treatment, patients will be informed of future maintenance needs and other potential costs associated with implant treatment after separation from active service.

e. Document patients' informed consent by completing the "Informed Consent for the Placement and Restoration of Osseointegrated Dental Implants" form, enclosure (3).

f. The Chairman of the Dental Implant Board should review the Dental Implant Program annually to ensure compliance with Bureau of Medicine and Surgery instructions.

6. Forms Availability. The forms enumerated in enclosures (2) through (4) may be reproduced locally as needed.

  
ROBERT E. HUTTO

Dist:  
List I, Case 1, 2

## DENTAL IMPLANT PROGRAM PROTOCOL

1. Program Goal. To provide a systematic approach to patient evaluation and treatment consistent with the contemporary scientific literature and within the operating resources of Naval Dental Center Southwest (NDCSW).

2. Background. The key elements of a dental implant program should encompass the following:

- a. Team approach to care.
- b. Careful diagnosis and treatment planning.
- c. Consideration of alternative conventional therapies.
- d. Patient education, consent, and commitment.
- e. Strictly followed surgical protocols.
- f. Adequate healing periods and progressive loading when appropriate.
- g. Precision fabrication and delivery of restorations.
- h. Axial loading – minimized lateral forces.
- i. Restoration designed for ease of hygiene.
- j. Careful follow-up and re-evaluation.
- k. Availability of care consistent with resources and mission of the facility.

3. Patient Selection Criteria

a. Priority

(1) Patients will be prioritized for implant therapy based on their Department of Defense eligibility for treatment.

(2) Active duty patients have the highest priority, but sufficient time must be available prior to their predicted rotation date or release from active duty to allow completion of treatment and appropriate follow-up. Generally, the patient cannot transfer out of the area for at least one year following completion of treatment or one and half years if the case required grafting.

Enclosure (1)

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(3) Retired personnel and/or family members of retired and active duty personnel may be accepted into the Implant Program for the education and training of dental specialists, to satisfy clinical requirements for board certification, and/or for the educational benefit of the AEGD and ACP training.

(4) Except for rare extenuating circumstances, no treatment will be initiated which cannot be completed by this facility, no implants will be placed for restoration by civilian practitioners, and no first time restorations will be fabricated and placed on implants placed by civilian practitioners for active duty patients unless the individual entered active duty with an unrestored implant or the implant was placed as a result of being assigned to a remote duty station where no military dentistry was available. Replacement or repair of implant restorations placed by civilian practitioners may be permitted, on a case-by-case basis, if the proper components can be obtained. Arrangements and a consultation with the expectant remote restorative provider are required prior to commencement of treatment if it will not be completed at NDCSW.

b. General Health. The patient must be free of significant systemic or local disease that would jeopardize the prognosis of the implants or place the patient at increased surgical risk. General contraindications to implant treatment include but are not limited to:

- (1) Tobacco use
- (2) Therapeutic radiation of potential implant sites
- (3) Metabolic bone disease
- (4) Bleeding disorders
- (5) Medications which affect healing (e.g., chronic steroid therapy, anticoagulants, etc.)
- (6) Insulin dependent diabetes
- (7) Poor oral hygiene habits

c. Oral Health Status. Patients with periodontal disease must, at a minimum, have successfully completed initial therapy prior to referral to the Dental Implant Board (DIB). All routine dental care and definitive periodontal therapy, necessary to render the patient disease free, must be completed prior to implant placement. Patients must display optimal oral hygiene and be able to return for routine follow-up appointments as deemed necessary. Particular attention must be paid to any patient who may have difficulty performing the hygiene procedures necessary to maintain implant restorations.

d. Anatomic Acceptability. Implant placement can only be considered at sites where adequate vertical and horizontal residual bone is present. Bone grafting or tissue guided techniques may be utilized to augment and enhance an implant recipient site; however, all bone

grafting techniques increase the surgical risk and need to be completed prior to presenting the patient before the Dental Implant Board. Other areas of concern include:

- (1) Anterior and posterior jaw relation discrepancies.
- (2) Adequacy of interarch and interdental space.
- (3) Adequacy of attached, keratinized tissue.
- (4) Occlusal scheme and parafunctional habits.
- (5) Ability to attain acceptable aesthetics.

e. Psychological Acceptability. Patients must have a firm commitment to be compliant with all pre and post-operative instructions. Psychological disorders, substance abuse, or unrealistic expectations preclude the use of dental implants.

f. General Indications for Implant Consideration

(1) Patients who have difficulty wearing a conventional prosthesis because denture-bearing tissues are unfavorable for support, retention, and/or stability.

(2) Patient demonstrates physiological intolerance to an otherwise acceptable conventional prosthesis (e.g., patients with low threshold for mucosal irritation from functional forces or those with hypersensitive gag responses.)

(3) Inability to achieve a successful restoration with a conventional prosthesis due to unfavorable residual ridge form, poor ridge relationships, or inadequate number and/or location of natural teeth abutments.

(4) Missing single teeth where adjacent teeth are unrestored or minimally restored.

(5) Patient's anatomic situation precludes an acceptable aesthetic result utilizing conventional prosthodontics (e.g., anterior disastemata).

(6) Implant treatment would eliminate the need for a poorly supported Kennedy Class I or II removable partial denture (especially for the mandible.)

(7) Patient occupation requires a fixed or stabilized restoration (e.g., diver, musician).

4. Dental Implant Board Evaluation

a. All patients to be considered as candidates for dental implant treatment must be evaluated by a command Dental Implant Board.

b. The Dental Implant Board requires the following information and materials for accurate review and consideration for acceptance to the program:

(1) Current radiographs (less than one year old) to include panoramic, periapicals and other views as indicated. When necessary, a computerized radiographic scan should be completed prior to presentation before the Dental Implant Board.

(2) A completed “Dental Implant Treatment Plan and Treatment Policy” [enclosure (2)].

(3) A completed “Informed Consent for the Placement and Restoration of Osseointegrated Dental Implants, [enclosure (3)], signed by the patient, the surgical or restorative provider, and a witness.

(4) Diagnostic Casts. Casts should be clear of positive or negative bubbles that interfere with articulation, and they should accurately reproduce oral structures while extending to the vestibular reflection. Sophisticated instrumentation for articulation of the casts is not necessary, but jaw relationships must be accurately reproduced.

(5) A diagnostic wax up that demonstrates the restoration’s contours and occlusion should be done.

(6) Photographs for slide presentation (optional).

c. All cases must be evaluated and prepared for presentation by an implant privileged restorative dentist and/or an implant privileged oral maxillofacial surgeon or periodontist. A pre-DIB diagnosis and treatment planning conference should be scheduled between the surgeon and the restorative dentist to solidify the information presented to the DIB. The following key elements should be considered for the presentation:

(1) Past dental history of the site(s) and adjacent area(s).

(2) The possible need for additional diagnostic imaging.

(3) Type of restorative abutment and treatment planned.

(4) The number, size, location, and depth of proposed fixtures to support the restorative treatment plan.

(5) The number, size, location, and depth of proposed fixtures in relationship to the surgical and restorative dimensions of the site.

(6) Specific functional and/or aesthetic requirements.

(7) The proposed treatment plan and sequence.

- (8) The possible need for site augmentation during Stage I surgery.

Alternative sites, fixture number, and fixture dimensions should be discussed preoperatively in the event that surgical limitations are discovered during Stage I surgery. The necessity for and the design of a surgical guide, the need for any interim restoration(s), and information regarding post-operative management should be reviewed.

d. Patient Case Presentation before the Dental Implant Board. Only cases that are ready for implant placement will be presented before the DIB. All pre-implant placement treatment (e.g. block grafts, ridge augmentation, orthodontic treatment, etc.) should be completed prior to case presentation. The presenter will use the information contained on the “Dental Implant Patient Treatment Plan and Treatment Policy” [enclosure (2)] for the presentation. Based upon a description of the anatomic site and its surgical and restorative dimensions, a proposed treatment plan will be offered for consideration by the DIB. This treatment plan will include any proposed restorative treatment and necessary surgical procedures.

e. Case Disposition. The Dental Implant Board approves patients for the implant program based on the information presented. The DIB will evaluate the information provided and decide upon the course of action. This may include:

- (1) Approval by the DIB of the patient and acceptance into the Dental Implant Program.
- (2) Disapproval by the DIB and rejection of the patient from the program.
- (3) Recommendations for further diagnostic work-up and re-presentation to the DIB.

If CT scan radiographic studies are indicated to complete the diagnostic and treatment planning phases, they must be made with a radiopaque surgical guide in place.

f. Patient Assignment and Treatment. All patients accepted into the Dental Implant Program will be assigned to a treatment team consisting of a restorative dentist and a primary surgeon. Patients referred to the DIB by branch clinics will generally be assigned to the team at that location within the constraints of budgetary and clinical privilege limitations. Two surgeons will be assigned to some cases to coordinate interdisciplinary surgical aspects of the case or to maximize training. In these instances, one surgeon will be designated as the primary surgeon. Both surgeons are expected to be present at Stage I surgical procedures.

## 5. Surgical Phase

a. All Stage I surgical procedures will be accomplished in the Naval Station BDC Oral and Maxillofacial Surgery or Periodontal surgical suites. Surgical scheduling will be coordinated through the surgical specialty performing the procedure (i.e., Periodontics or Oral and Maxillofacial Surgery). Surgical procedures will be conducted per accepted surgical standards, proper infection control techniques, and manufacturer protocols. Any grafting or tissue guidance

techniques will be performed in compliance with approved research protocols or standards of care.

b. Presurgical Treatment Planning. A presurgical conference must be scheduled between surgeons and restorative dentists for reviewing:

- (1) The proposed treatment plan and sequence.
- (2) Any specific functional and/or aesthetic requirements.
- (3) The number, size, location, and depth of the proposed fixture(s).
- (4) The type of restorative abutment planned.
- (5) The need for Stage I fixture indexing.

c. Stage I Surgery. The assigned primary surgeon is responsible for:

(1) Complete familiarization with the surgical instrumentation, armamentarium, and procedures for the type of implant(s) being placed.

(2) Contacting the patient and coordinating the surgery date. The surgeon should coordinate any surgical dates with the assigned restorative dentist so that:

(a) Appropriate surgical guides will be fabricated and made available for surgery.

(b) The restorative dentist will be available to provide consultation (if necessary) to the surgeon regarding positioning of the fixture(s) during the surgery.

(3) Assigning a surgical technician(s) that is completely familiar with the surgical instrumentation, armamentarium, and procedures for the type of implant being placed.

(4) Assigning and posting a surgery date that doesn't conflict with an existing planned surgery date of another team.

(5) Consulting the assigned restorative dentist for the selection of the type of healing abutment desired at Stage II surgery. This needs to be done well in advance of the planned Stage II surgical date to ensure availability of the desired healing abutment.

(6) For cases involving only a single stage surgical procedure, the above steps may be combined.

6. Surgical Guides. The use of a surgical guide is recommended with Stage I fixture placement surgeries. The restorative dentist is responsible for the fabrication of the surgical guide following consultation with the surgeon.

7. Healing. The healing interval between Stage I and II surgeries should reflect bone density, fixture stability at placement, and use of grafting materials. Healing guidelines include:

- a. Mandibular anterior: 3-4 months
- b. Mandibular posterior: 4-6 months
- c. Maxilla: Ideal quality – 6 months; poor quality – 8-9 months
- d. Osseous augmentation at Stage I or Type IV bone: 6-9 months

8. Restorative Phase. When the definitive abutment is placed, the fit of the fixture-abutment interface must be radiographically verified prior to applying appropriate torque. All implant superstructures must be carefully evaluated to insure passive fit to abutments. Occlusal forces should be directed in an axial direction and occlusal schemes designed to minimize horizontal and lateral stresses. All implant restorative treatment must be accomplished under the supervision of a staff prosthodontist or restorative dentist privileged in dental implant treatment.

9. Maintenance Care. Patients must be instructed in the proper techniques for hygiene and the continuing need for professional maintenance. Recall schedules should reflect complexity of treatment. It is recommended all implant restorations be re-evaluated at six and twelve months, then annually thereafter. Routine removal of definitive abutments is not recommended. For patients treated at NDCSW, a maintenance program should be integrated with the Hygiene Department. Dental personnel trained in the appropriate manipulation and care of implant prostheses will perform calculus and plaque removal. Specific areas to be re-evaluated at follow-up appointments include:

- a. Occlusion
- b. Oral hygiene and periabutment soft tissue health
- c. Crestal bone levels as viewed on serial radiographs
- d. Integrity of attachment systems
- e. Stability of the implants

10. Follow-up. Implant treatment, routine and emergency maintenance, and repairs are not available at all Navy dental clinics/ hospitals/ships. Active duty patients will be seen at the treatment team's facility for all needed follow-up care while stationed for duty in the San Diego area. Upon transfer, active duty personnel may have to seek such care at other military facilities or at their own expense from civilian providers. Upon retirement, EAOS, early or unplanned separation, continued care and maintenance of implants must be provided by civilian providers without reimbursement from the government. Patients other than active duty personnel will have

a restricted follow-up period of two years after placement of the implant restoration. Patients must assume all responsibility for their implant care and maintenance, and understand that they may have to seek care on a space available basis, if eligible and available, at military dental facilities, or from civilian providers, without reimbursement from the government.

11. Complications. A completed “Dental Implant Complication Report,” [enclosure (4)], must be sent to the Command Coordinator/Consultant for Dental Implants whenever a complication related to treatment is encountered which significantly alters treatment sequence or outcome. Complications will be reviewed periodically at Dental Implant Board meetings. An appropriate occurrence screen should be initiated. Complications that require documentation include:

- a. Post-surgical or post-restoration delivery infection
- b. Persistent (+ 2 month) nerve dysesthesia or paresthesia
- c. Damage to adjacent teeth during surgical treatment
- d. Loss of osseointegration
- e. Component or equipment failure
- f. Significant crestal bone loss

12. Patient Record Entries. Distortion free periapical radiographs, clearly demonstrating the crestal bone height at delivery and subsequent follow-up visits, must be retained in the patient’s dental treatment record. Surgical and restorative record entries must include the standard information pertinent to treatment in addition to:

- a. Surgical
  - (1) Implant fixture manufacturer, type, lot number, length and diameter.
  - (2) Implant recipient site (by corresponding tooth number).
  - (3) Type of bone (if known) at implant site(s) (Zarb classification 1-4).
  - (4) Surgical/procedural complications or modifications
  - (5) Placement of graft material.
  - (6) Size of healing abutment

b. Restorative

- (1) Manufacturer, type, size and lot number of definitive abutment(s).
- (2) Manufacturer, type and lot number of retaining/abutment screw(s), and final torque.
- (3) Material(s) used to obturate screw access channels.
- (4) Manufacturer, type, size and lot number of attachment systems.

13. Equipment and Supply Management

a. The Command Coordinator/Consultant for Dental Implants will purchase all dental implant components and surgical instrumentation used in the treatment of patients for dental implants.

b. Consumable surgical implant components (e.g., fixtures/healing abutments, etc.) will be stored in the Periodontics or Oral and Maxillofacial Surgery Department, Branch Dental Clinic (BDC), Naval Station San Diego. The Custodian of the Surgical Implant Equipment, Instrumentation and Components will be assigned by the Command Coordinator/Consultant for Dental Implants and will be responsible for ensuring that surgical materials are available for Stage I and Stage II procedures. The primary surgeon assigned to a case will verify the availability of required components.

c. Consumable restorative components will be stored in the Prosthodontics Department Head's Office. The Command Coordinator/Consultant for Dental Implants will maintain and issue restorative components. Restorative components can be obtained as needed from the inventory, or by requesting them from the Command Coordinator/Consultant for Dental Implants. An inventory of restorative components is located inside the storage cabinet and should be amended to reflect the numbers of remaining components once a desired component is removed. Specific precision attachments and restorative components may not be routinely stocked and may require special purchasing. Hand instrumentation to include a manual torque driver will be available within the Prosthodontics Department. An electronic torque controller is available on a checkout basis from the Command Coordinator/Consultant for Dental Implants.

14. Requirements for Obtaining Privileges in Dental Implant Treatment and/or Maintenance.

Clinical privileges for both the surgical and restorative aspects of dental implant treatment and for dental implant maintenance will be recommended for individuals based upon past education, implant training, and experience. For non-privileged NDCSW staff, privileges may be applied for after successful completion of a BUMED/Specialty Leader for Dental Implantology approved basic didactic course and mentored clinical experience provided by staff personnel privileged in implant placement, restoration and maintenance.

**Dental Implant Patient Treatment Plan**  
 (This section to be completed by provider)

**Naval Dental Center Southwest**

\_\_\_\_\_  
 PATIENT NAME (LAST, FIRST, M.I.)

\_\_\_\_\_  
 PRESENTED BY

\_\_\_\_\_  
 DATE PRESENTED

\_\_\_\_\_  
 PATIENT SSN

\_\_\_\_\_  
 SERVICE

\_\_\_\_\_  
 RANK/RATE

\_\_\_\_\_  
 STATUS

\_\_\_\_\_  
 DOB

\_\_\_\_\_  
 PRD/EAOS/LEAVING  
 SAN DIEGO AREA

\_\_\_\_\_  
 PATIENT DUTY STATION

\_\_\_\_\_  
 PATIENT MAILING ADDRESS (NUMBER AND STREET)

\_\_\_\_\_  
 PATIENT MAILING ADDRESS (CITY, STATE, AND ZIP CODE)

\_\_\_\_\_  
 PATIENT WORK PHONE

\_\_\_\_\_  
 PATIENT HOME PHONE

\_\_\_\_\_  
 CELL PHONE

\_\_\_\_\_  
 E-MAIL ADDRESS

Pertinent History: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgical Site Evaluation**

Tooth #	Siebert Class	Crest/Apical	M-D	B-L	Inter-Rradicular	Interarch

**Surgical/Restorative Plan**

Tooth #	Graft (if done)	Fixture	Abutment	Final Restoration

\_\_\_\_\_  
 SURGEON I

\_\_\_\_\_  
 SURGEON II

\_\_\_\_\_  
 PROSTHODONTIST

\_\_\_\_\_  
 RESIDENT

\_\_\_\_\_  
 STAGE I DATE

\_\_\_\_\_  
 STAGE II DATE

\_\_\_\_\_  
 DELIVERY DATE

## **Dental Implant Patient Treatment Policy**

You are being evaluated as a potential candidate for dental implants. Opportunities to undergo this specialized and expensive treatment are **extremely limited** and selection for treatment is based upon several factors. Active duty personnel take precedence over retired/dependents. The results of your examination will be presented to the command's Dental Implant Board for preliminary review. No commitment for treatment with implants will be made until the board approves you for treatment and a definitive treatment plan is completed, possibly following further examination.

***Additional requirements, if accepted for treatment, are as follows:***

- 1) You must be available throughout the entire course of treatment (1-2 years). No request for orders extension will be supported to gain access to this treatment.
- 2) There may be instances where you will be instructed not to wear your partial or complete dentures for a period of two weeks or more following implant surgery. Compliance with this and all other instructions is critical to successful treatment.
- 3) Smoking has been shown to reduce the success of implant treatment. Permanent smoking cessation is mandatory prior to initiating treatment.

**Active duty personnel must carefully read and initial the following paragraph**

\_\_\_\_\_ I understand that implant treatment, routine and emergency maintenance and repairs is not available at all Navy dental clinics/hospitals. I will be seen at this facility for all needed follow-up while stationed for duty in the San Diego area. Upon my retirement or separation, I understand I may have to seek such care at other military facilities or from civilian providers – without reimbursement. Dental implant maintenance can be very expensive and I accept responsibility for the potential costs.

**Retired or dependent personnel must carefully read and initial the following paragraph**

\_\_\_\_\_ I understand that this facility will provide access for one year of follow-up care following completion of treatment. After that time, I will assume all responsibility and understand that I may have to seek such care on a space available basis at available military dental facilities or from civilian providers – without reimbursement. Dental implant maintenance can be very expensive and I accept responsibility for the potential costs.

I have read and understand the above policy concerning patient selection and treatment with dental implants.

\_\_\_\_\_  
**Patient signature**

\_\_\_\_\_  
**Date**

**INFORMED CONSENT**  
**FOR THE PLACEMENT AND RESTORATION**  
**OF OSSEOINTEGRATED DENTAL IMPLANTS**

Naval Dental Center Southwest  
San Diego, California 92136

This is my consent for the surgical placement, uncovering and restoration of dental implants. I understand the procedure will involve the placement of titanium metal dental implant(s) into my jaw. The implants must heal for 4 to 8 months before being surgically uncovered so the restoration can be made at a later date. The implants may then be used to support and retain partial dentures, complete dentures, or to replace single missing teeth. I have been informed of alternative methods of treatment along with their risks and benefits.

I understand that there is no way to predict the gum and bone healing response following implant placement. Factors such as general health, smoking, alcohol and poor diet may affect healing and the success of the implant.

It has been explained that there are risks associated with this treatment, including the possibility of pain, bleeding, swelling, and infection. Numbness and/or tingling of the lip, tongue, chin, gums, cheeks and any existing teeth can also occur, which may be temporary or permanent. Additionally, sinus complications, openings from the sinus to the mouth, bone fractures, injuries to adjacent tissues and apparent facial changes are possible. These problems may require later surgical correction including removal of the device. Furthermore, it has also been explained to me that the implant(s) may not work, or may later fail. I understand that failure of this implant method may result in failure of the bridge, partial or full denture but will usually not interfere with other types of future conventional denture treatment should that be necessary.

(Please read and initial the following statements)

\_\_\_\_\_ I agree to the use of a local anesthetic, and/or sedation or general anesthetic depending upon the judgment of the surgeon and/or anesthesiologist involved in my care.

\_\_\_\_\_ I understand that a bone graft material may need to be added to help support the implant. The graft material is usually a decalcified freeze-dried bone which is obtained by certified tissue banks under sterile conditions from human donors with no known diseases. The bone is then processed under strict conditions which are known to kill bacteria and viruses. While transmission of infection by implanted biologic material can never be ruled out 100% of the time, this material is considered to be extremely safe with no instance of transmitted infection found in more than 10 years of use. Sometimes a synthetic membrane will also be used to protect the bone graft. Some of these membranes need to be surgically removed at a later date.

\_\_\_\_\_ I have had an opportunity to discuss my past and current medical history including any serious problems and/or injuries with my doctors. I have disclosed any medications I am taking.

\_\_\_\_\_ I understand that I may be instructed not to wear my dentures for 2-3 weeks following implant placement. Compliance with this instruction is critical to successful implant treatment.

\_\_\_\_\_ Non-active duty beneficiaries are treated on a space available basis. I understand every effort will be made to provide two years of follow up after the implants are restored. After two years, I may have to seek further follow up care and maintenance with civilian dentists at my own expense.

Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination that can be increased by the use of alcohol and other drugs. 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 their effects. I will not be able to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

I understand the importance of cooperating completely with the recommendations of my doctors while I am under their care. Failure to do so could result in a less than optimum result. As dental implant treatment is sophisticated and expensive, I agree to be available for treatment and follow-up appointments as necessary. I also understand the need and importance of maintaining proper oral hygiene. Like natural teeth, if dental implants are not properly cared for daily they will lose supporting bone through disease and will need to be removed.

Additional information regarding my care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand there is no warranty or guarantee as to the results or outcome of placement of implants and that my condition could actually become worse if the implant(s) fail.

I certify that I have read and fully understand the terms and words within this informed consent document and have had the opportunity to discuss the surgical operation and prosthetic restoration of my mouth to my satisfaction.

\_\_\_\_\_  
**Printed or Typed Patient Name**

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

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed/Typed/Stamped Name of Provider**

\_\_\_\_\_  
**Signature of Doctor**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed/Typed Name of Witness**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

# DENTAL IMPLANT COMPLICATION REPORT

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The NDCSW Command Coordinator/Consultant for Dental Implants must be notified when a complication related to treatment is encountered. Complications, which require notification, include:

1. Infection: post-surgical or post restoration delivery
2. Persistent (>2 month) nerve dysesthesia or paresthesia
3. Damage to adjacent teeth during surgical treatment
4. Loss of osseointegration
5. Component or equipment failures
6. Significant crestal bone loss

Reports will be reviewed periodically at the NDCSW Dental Implant Board meeting.

Please provide the following information:

Patient Name (Last, First, MI): \_\_\_\_\_ Date of Report: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_ Patient Rank: \_\_\_\_\_

Individual Making Report: \_\_\_\_\_

Description of event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TREATMENT DATES: Stage I: \_\_\_\_\_ Stage II: \_\_\_\_\_ Completion: \_\_\_\_\_

Surgeon(s): \_\_\_\_\_

Restorative Dentist(s): \_\_\_\_\_

Treatment Action Required to Remedy Event: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Outcome: \_\_\_\_\_

\_\_\_\_\_