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ONE STOP
Implant Training,
Technology & Support

Patient Implant Screening Plan

This Patient Implant Screening Plan is designed to assist you, the patient, in evaluating whether dental implants are a viable option for your dental problems. Should this initial screening prove you to be a candidate for dental implants, we will recommend the number and location of implants and cost estimates for treatment. There is no charge by us for this initial evaluation. The suggested implant screening plan is offered on the understanding that the patient wishes a preliminary screening of their current dental needs with a treatment plan involving implants and is offered only as a guide. Ultimate responsibility for acceptance of and for your treatment lies with the surgical clinician, the restoring clinician, the dental laboratory and the patient.

Please complete the back page and return this form along with a recent (within 1 year) Panograph x-ray and/or periapical x-rays of your mouth. X-rays or copies of existing x-rays are available from your local dentist.

Should natural teeth be present in your mouth, please also provide us with trimmed study models mounted on a Vertex type articulator. These can be obtained from your dentist or denturist.

Please sign the bottom of the back page and forward the form and other items to the address noted below.

One of our experienced implant consultants will study and evaluate your information and suggest a personal treatment plan. The suggested treatment plan is not to be considered as absolute but can be modified based upon the experience of the persons who will actually place and restore the implants.

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Date: ____________________ How did you hear about us?: ____

Patient Name: ____ Age: __________ Sex: ________________

Address: ____ City: __________________________

State/Prov: _______________ Postal code _____________________ Phone: ____________________________

Fax: ______________________ e-mail: _________________________ Best Time to Call: __________________

Teeth

What Is Your Main Dental Concern, Appearance/Discomfort/Unable to Eat?. Please elaborate:

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Health

1. Are you in good health? Y/N
2. Have you had recent surgery, medical treatment, taking medicines or aware of any problems? Y/N
3. Are you allergic to any medicines? Y/N
4. Do you have any of the following habits or problems?

- Smoking - Alcohol - Drugs - Bruxism - Diabetes - Bone disease - History of Periodontal Disease

- Heart Problems - Heart Attack - Stroke - Asthma - Bronchitis - Drug Reaction - Blood thinners

Please elaborate: ____

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Signature: ____