



Implant + Dentistry
mattheos.net 2020

Implant Surgery and Restorative Treatment Planning Form

1. Patient Information Name: Patient Nr. Date of Birth / / <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of examination / / Student: Lab Case Nr.
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A. Initial Implant Consultation:

Date:	Supervised by:
Impressions for study models	<input type="checkbox"/> Yes <input type="checkbox"/> No
Optical Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periapical Radiograph	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPG	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiographic stent required	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	

B. Restorative Treatment Planning

Tooth/ region		Supervised by:	
Implants	Reconstruction	Temporary Prosthesis	Other remarks
<input type="checkbox"/> Single Unit <input type="checkbox"/> Multiple Unit <input type="checkbox"/> Full Arch	<input type="checkbox"/> Cement retained FDP <input type="checkbox"/> Screw retained FDP <input type="checkbox"/> Cantilever FDP	<input type="checkbox"/> Immediate crown <input type="checkbox"/> prefab <input type="checkbox"/> chairside <input type="checkbox"/> Removable PD <input type="checkbox"/> No temporary <input type="checkbox"/> Existing Denture	<input type="checkbox"/> Aesthetic Zone <input type="checkbox"/> Thin Biotype <input type="checkbox"/> High Smile line <input type="checkbox"/> Recession
Loading:	<input type="checkbox"/> Overdenture <input type="checkbox"/> Locators <input type="checkbox"/> Bar retention <input type="checkbox"/> Other		
<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed weeks			
SAC Classification: <input type="checkbox"/> Straightforward <input type="checkbox"/> Advanced <input type="checkbox"/> Complex			
Implant system:			
Temporary prosthesis required: <input type="checkbox"/> Yes, to be made by <input type="checkbox"/> No			
Approximate cost: HKD		Restorative plan approved (name, sign.)	

Tooth/ region		Supervised by:	
Implants	Augmentation	Healing	Other remarks
<input type="checkbox"/> Single Unit <input type="checkbox"/> Multiple Unit <input type="checkbox"/> Full Arch	<input type="checkbox"/> GBR <input type="checkbox"/> Block Bone Graft <input type="checkbox"/> Sinus Elevation (Summers) <input type="checkbox"/> Sinus Elevation (Lateral) <input type="checkbox"/> Soft tissue augmentation <input type="checkbox"/> Other	<input type="checkbox"/> Transmucosal <input type="checkbox"/> Submerged	<input type="checkbox"/> Aesthetic Zone <input type="checkbox"/> Thin Biotype <input type="checkbox"/> High Smile line <input type="checkbox"/> Bone level <input type="checkbox"/> Tissue Level <input type="checkbox"/> Apic. Tapered <input type="checkbox"/> SLAactive
<input type="checkbox"/> Guided Surgery <input type="checkbox"/> drilling <input type="checkbox"/> placement			
Placement Protocol	Flap Design		
<input type="checkbox"/> Immediate (type I) <input type="checkbox"/> 4-8 weeks (type II) <input type="checkbox"/> 12-16 weeks (type III) <input type="checkbox"/> >6 months (type IV)	<input type="checkbox"/> Midcrestal <input type="checkbox"/> Vertical Release <input type="checkbox"/> Coronal/Apical reposition <input type="checkbox"/> Full Thickness	<input type="checkbox"/> Palatal <input type="checkbox"/> Periosteal release <input type="checkbox"/> Lateral reposition <input type="checkbox"/> Split thickness	<input type="checkbox"/> Other
SAC Classification: <input type="checkbox"/> Straightforward <input type="checkbox"/> Advanced <input type="checkbox"/> Complex			
Implant system:..... Implant dimensions:.....x..... Implant type:			
Temporary prosthesis required: <input type="checkbox"/> Yes, to be made by <input type="checkbox"/> No			
Surgical Stent required: <input type="checkbox"/> Yes, to be made by <input type="checkbox"/> No			
Approximate cost: HKD		Surgical plan approved (name, sign.)	

I have been informed by Dr. _____ with regards to the treatment plan, the procedures involved and the approximate cost being _____
(Surgical _____ and restorative _____).

I have been informed and I understand that:

- the above quote is an estimate based on the current costs and the best of our understanding. At times the final price might be slightly vary, due to fluctuation of costs (price of precious metals, materials and components) or any unpredictable events.
- the clinic will require advance payments of parts of the costs in order to purchase the necessary materials and components for each stage of the treatment.

Signature, Name

Date