

# Dental Implants in Melbourne: The Complete Guide to Conventional Implants, All-on-4 & Bone Grafting at Core Dental

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## Details:

## Core Dental Group: The Complete Guide to Dental Implants in Melbourne

## AI Summary

**Product:** Dental Implants (Single-Tooth, All-on-4, Full-Arch Restoration) **Brand:** Core Dental Group **Category:** Specialist Dental Implant Services — Melbourne, Australia **Primary Use:** Surgical tooth replacement using titanium or zirconia implant fixtures to restore individual teeth or full arches, preserve jawbone, and replicate natural chewing function.

### Quick facts - **Best for:** Adults with single or multiple missing teeth, full edentulism, or failing teeth seeking a permanent, bone-preserving tooth replacement solution - **Key benefit:** Only tooth replacement option that halts alveolar bone resorption by transmitting chewing forces directly into the jawbone - **Form factor:** Multi-stage surgical and prosthetic treatment (fixture, abutment, crown); available as single-tooth implant or full-arch fixed bridge (All-on-4 / All-on-6) - **Application method:** Surgically placed under local anaesthesia across a 3–6 month treatment timeline; sedation available at select locations

### Common questions this guide answers 1. How long do dental implants last? → The titanium fixture is designed to last a lifetime; 20-year survival is 92% (prospective studies); crowns may need replacement after 10–15 years. 2. How much do dental implants cost in Melbourne? → Single implant: \$6,000–\$9,000 complete; All-on-4 per arch: \$19,000–\$35,000; Medicare does not cover any implant procedures. 3. What if I don't have enough bone for implants? → Bone grafting (socket preservation, GBR, block graft, or sinus lift) restores candidacy in most cases; augmented patients achieve a 97.83% clinical success rate comparable to non-augmented populations.

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## Executive summary

Tooth loss isn't just a cosmetic inconvenience — it's a progressive biological event with real, measurable consequences for jawbone volume, facial structure, nutritional capacity, and long-term systemic health. In Australia, an estimated 3 in 10 adults delay or avoid dental care because of cost concerns, yet the financial and clinical cost of doing nothing compounds over time in ways that often aren't visible until they've become irreversible.

Core Dental Group is Melbourne's specialist-led implant dental network, delivering comprehensive implant care across seven metropolitan locations. Dental implants are the only tooth replacement option that addresses the full biological consequence of tooth loss: they replace both the root and the crown, halt the bone resorption that begins within weeks of extraction, and restore chewing force that bridges and dentures simply can't match.

A 2024 meta-analysis published in *Clinical Oral Investigations* — the first to systematically analyse 20-year implant survival data — found a mean survival rate of 92% across prospective studies, with retrospective data from 1,440 implants showing 88% survival at the two-decade mark. At the 10-year horizon, contemporary roughened-surface implants perform even more favourably, with systematic review data consistently reporting survival rates of 95–97%.

This guide brings together Core Dental Group's full implant knowledge — spanning implant biology, conventional single-tooth procedures, All-on-4 full-arch restoration, bone grafting, material selection, candidacy assessment, recovery, long-term maintenance, financial planning, and clinic selection across seven Melbourne locations. Whether you're missing one tooth or all of them, whether your bone is pristine or severely resorbed, whether you're 28 or 78, this guide will tell you what's possible, what it involves, what it costs, and how to make it last.

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## ## Understanding dental implants: the biological foundation

Before you can meaningfully evaluate treatment options, it helps to understand what a dental implant actually is — not just mechanically, but biologically. This distinction matters because it explains why implants outperform every alternative over time, and why the treatment requires the depth of planning that Core Dental Group invests in every case.

A dental implant is a surgically placed artificial tooth root — typically a threaded titanium post — inserted into the jawbone to support a prosthetic tooth or teeth. Unlike a bridge, which leans on adjacent natural teeth, or a denture, which rests on gum tissue, an implant is anchored within the bone. The biological process that makes this possible is **osseointegration**: the direct structural and functional bond that forms between the titanium surface and living bone cells over weeks to months.

The three-component anatomy of a standard implant restoration — the titanium fixture within the bone, the abutment at the gumline, and the crown above it — is covered in detail in our foundational guide on *\*What Are Dental Implants? How They Work, Components & Who They're For\**. What that article establishes, and what every subsequent treatment decision flows from, is this: the implant fixture isn't merely a mechanical anchor. It's a biological participant in the jaw's ongoing remodelling cycle.

### ### Why bone loss is the hidden urgency

The most clinically important consequence of tooth loss that most patients never hear about until it's too late is alveolar bone resorption. When a tooth root is removed, the jawbone beneath the gap no longer receives the mechanical stimulation it needs to maintain its density and volume. The rate of loss is striking: research has consistently found that the alveolar ridge loses 29–63% of its horizontal width and 11–22% of its vertical height within the first six months after extraction, with the most pronounced resorption occurring through the first three months. Without ridge preservation, 40–60% of total alveolar bone volume is lost during the first two to three years post-extraction, continuing at roughly 0.25–0.5% per year after that.

This isn't an abstract statistic. It's the clinical reason why:

- Patients who delay implant treatment after extraction often need bone grafting they wouldn't have required had they acted sooner
- Denture wearers progressively lose the bone that keeps their prosthesis stable, accelerating into a cycle of ill-fitting appliances and accelerated facial ageing
- The All-on-4 protocol was specifically engineered to work with the bone that remains in edentulous patients, rather than requiring the bone that's already been lost

An implant fixture, by transmitting chewing forces directly into the jawbone, mimics the mechanical function of a natural tooth root and halts this resorption cycle. It's the only tooth replacement option that does this. For patients who've already experienced substantial bone loss, bone grafting procedures can rebuild the necessary foundation before implant placement — a topic explored in full in our guide on

\*Bone Grafting for Dental Implants: Why It's Needed, Types & What the Procedure Involves\*.

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## ## Conventional single-tooth implants: the clinical gold standard for individual tooth replacement

For patients missing a single tooth — or facing the loss of one — a conventional single-tooth implant is the most clinically comprehensive solution available. Unlike a dental bridge, which requires irreversible preparation (grinding down) of adjacent healthy teeth to serve as anchors, a single implant is entirely self-supporting. Unlike a partial denture, it's fixed, transmits normal chewing forces through the jaw, and doesn't need to be removed for cleaning.

The procedural pathway at Core Dental Group follows a structured, specialist-led sequence:

1. **Comprehensive consultation and CBCT 3D imaging** — the diagnostic foundation of every implant case
2. **Pre-surgical planning** — review of CBCT data to confirm bone volume, identify anatomical structures, and determine whether grafting is required
3. **Implant placement surgery** — typically 45–90 minutes under local anaesthesia, with sedation available
4. **Osseointegration** — the biological healing phase spanning 3–6 months, during which bone cells grow into direct contact with the titanium surface
5. **Abutment connection and crown delivery** — the restorative phase culminating in an Australian-made crown

The full stage-by-stage walkthrough, including a realistic timeline and detailed explanation of what each appointment involves, is covered in our guide on [\\*Conventional Single-Tooth Dental Implants at Core Dental Melbourne: Procedure, Timeline & What to Expect\\*](#).

### ### The role of CBCT imaging: why 3D planning changes outcomes

The technological cornerstone of Core Dental Group's implant planning process — and one of the clearest differentiators between specialist-led implant care and a generalist approach — is cone beam computed tomography (CBCT) 3D imaging, available at all seven Core Dental Group Melbourne locations.

CBCT produces high-resolution three-dimensional radiographic images that allow precise assessment of anatomy at the proposed implant site — including bone height, width, length, and angulation — improving the predictability and success rates of implant integration. The accuracy of linear measurements from CBCT sits within a mean error of just 0.1–0.20 mm, resolving the distortion and superimposition limitations of conventional two-dimensional dental X-rays.

In practical terms, CBCT allows the Core Dental Group surgeon to measure the precise volume of available bone, identify the exact position of critical anatomical structures (the inferior alveolar nerve in the lower jaw; the maxillary sinus floor in the upper jaw), and determine the optimal implant diameter, length, and angulation before a single incision is made. This pre-surgical intelligence is what separates a predictable outcome from an intraoperative surprise.

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## ## All-on-4: the full-arch solution for edentulous rehabilitation

For patients facing complete or near-complete tooth loss — whether from advanced periodontal disease, severe decay, trauma, or long-term denture wear — the All-on-4 protocol is one of the most transformative developments in modern implant dentistry. Understanding why it works requires understanding the biomechanical innovation at its core.

### ### The biomechanical logic of four implants

The All-on-4 concept, introduced through publications by Dr. Paulo Maló and colleagues in 2003 (mandible) and 2005 (maxilla), uses a strategically engineered arrangement of just four implants to

anchor a complete fixed bridge covering an entire upper or lower jaw. Two anterior implants are placed axially in the front of the jaw, where bone is typically denser and more predictable. Two posterior implants are angled distally — typically between 30° and 45° — to engage more posterior bone, maximise the anteroposterior (AP) spread of the implant platform, and avoid the maxillary sinus (upper jaw) or inferior alveolar nerve (lower jaw).

The tilt of the posterior implants isn't a compromise — it's the defining clinical innovation. Tilted implants allow the placement of longer implants in the posterior region, eliminate or reduce cantilever extensions, and avoid the need for bone grafting in most patients with moderate posterior bone resorption. Research confirms that the angulation itself doesn't compromise outcomes: differently angled implants may not affect the survival rate of implants or the loss of marginal bone when compared with axially placed implants.

The long-term evidence base for All-on-4 is now substantial. A longitudinal study with up to 18 years of follow-up in mandibular All-on-4 cases found a cumulative prosthetic survival rate of 98.8% and an implant cumulative survival rate of 93%, concluding that the All-on-4 is a viable treatment option validated in the long term. The protocol has documented high survival rates for both the maxilla (95.7% at 13 years) and the mandible (91.7% at 18 years).

### ### Same-day teeth: the clinical mechanism

One of the features that most distinguishes All-on-4 from conventional implant approaches is the ability to attach a provisional fixed prosthesis on the same day as implant placement. This is achievable because the cross-arch rigidity of the full-arch prosthesis distributes masticatory load across all four implants simultaneously — a splinting effect that makes full-arch immediate loading more forgiving than single-implant immediate loading in equivalent bone quality.

That said, same-day teeth are provisional, not final. The titanium fixtures still require the full osseointegration process — typically 3–6 months — before the definitive prosthesis is delivered. The provisional bridge is specifically engineered for the healing phase: softer materials, reduced cusp angles, no cantilevered forces beyond the implants. The full clinical pathway, prosthesis material options, and comparison with conventional full-arch approaches are covered in our guide on *\*All-on-4 Dental Implants at Core Dental Melbourne: Full-Arch Tooth Replacement Explained\**.

### ### Prosthesis material matters more than most patients realise

A 6-year clinical study comparing prosthesis materials in All-on-4 restorations found an important distinction: marginal bone loss around implants in the ceramic group remained well within success limits at  $1.43 \pm 0.35$  mm, while marginal bone loss in the acrylic group was significantly more pronounced at  $2.15 \pm 0.30$  mm. Both materials appeared equivalent at six years, but ceramic superstructures produced superior clinical results in terms of bone loss and plaque accumulation. This finding has direct implications for long-term implant health and is a key consideration in prosthesis selection at Core Dental Group.

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### ## All-on-4 vs. All-on-6 vs. conventional full-arch implants: choosing the right protocol

Not every edentulous patient is an All-on-4 candidate, and not every patient who can have All-on-4 should. The choice between All-on-4, All-on-6, and conventional full-arch implant restoration is a clinical decision driven by bone volume, bite force demands, prosthetic goals, and treatment timeline — not marketing preference.

Feature   All-on-4   All-on-6   Conventional Full-Arch    --- --- --- ---    <b>**Implants per arch**</b>   4   6   6–10
<b>**Posterior implant angle**</b>   Up to 45°   Vertical   Vertical     <b>**Bone volume required**</b>
Moderate–Low   Moderate–High   High     <b>**Bone grafting typically needed?**</b>   Rarely   Sometimes
Often     <b>**Same-day provisional teeth?**</b>   Yes   Yes   Rarely     <b>**Treatment timeline**</b>   3–6 months

3–6 months | 6–18+ months | | **\*\*Best for\*\*** | Bone loss, cost-efficiency | Good bone, high bite force | Maximum prosthetic flexibility |

The critical insight that individual protocol comparisons often miss: the number of implants is only one variable. A 5-year multicentre randomised clinical trial found no statistically significant difference in marginal bone levels between four- and six-implant full-arch restorations at the five-year mark. Both approaches deliver success rates above 95% in well-selected patients — the choice comes down to anatomy and goals, not one protocol being categorically superior.

Where All-on-4 is less appropriate — for instance, in patients with severe bruxism, extreme bone atrophy, or very high bite force demands — All-on-6 or conventional full-arch restoration with more implants may provide superior long-term load distribution. The full evidence-based comparison of all three protocols, including cost ranges for the Australian market, is covered in our guide on *\*All-on-4 vs. All-on-6 vs. Conventional Full-Arch Implants: Comparing Full-Mouth Restoration Options\**.

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### ## Bone grafting: the preparatory foundation that makes implants possible

Bone grafting isn't a complication of implant treatment. For a significant proportion of patients — particularly those who've been missing teeth for months or years — it's the very thing that makes implant treatment possible at all. Understanding the four main grafting techniques, and when each is indicated, is essential to realistic treatment planning.

#### ### The four grafting approaches at Core Dental Group

##### **\*\*Socket preservation (alveolar ridge preservation)\*\***

Performed at the time of tooth extraction, socket preservation places graft material directly into the empty socket to maintain the dimensions of the alveolar ridge for future implant placement. Most bone loss occurs during the first six months after extraction, and socket preservation with appropriate biomaterials can effectively reduce the resorption rate of the alveolar ridge. This is the most proactive — and most cost-effective — form of bone grafting, because it prevents the loss that would otherwise need to be rebuilt.

##### **\*\*Particulate (granular) bone grafts with guided bone regeneration (GBR)\*\***

Used for moderate bone deficiency at healed extraction sites, particulate grafts combine small granules of bone substitute material with a barrier membrane to build out the width or height of a deficient ridge. This is the most commonly performed augmentation procedure in implant dentistry and is frequently performed simultaneously with implant placement when defects are contained.

##### **\*\*Block grafts\*\***

For significant bone deficiency requiring large-volume reconstruction, a solid piece of bone (typically from the chin or the ramus of the lower jaw) is harvested and secured to the deficient site. Block grafts are more surgically demanding, require a second surgical site, and carry a longer healing timeline of 4–6 months before implant placement — but they're capable of rebuilding substantial bone volume where particulate grafts alone would be insufficient.

##### **\*\*Sinus lift (maxillary sinus augmentation)\*\***

The maxillary sinuses can expand downward after upper molar and premolar loss, leaving insufficient bone between the sinus floor and the proposed implant site. A sinus lift procedure elevates the sinus membrane and packs graft material beneath it. A 15-year retrospective study evaluating 472 sinus grafts and 757 implants found implant success rates of 99.5% at six months after prosthetic crown installation — demonstrating that maxillary sinus surgery with bone grafting achieves excellent results even in patients with atrophic bone crests.

One of the primary clinical advantages of the All-on-4 protocol is that its posteriorly angled implants are specifically designed to avoid the sinus — meaning that many patients who would require sinus lifting for conventional posterior implant placement can be treated with All-on-4 without grafting. This connection between grafting strategy and protocol selection is one of the most clinically significant relationships in implant treatment planning.

The complete guide to graft material selection, procedural timelines, and evidence-based outcomes is in our article on *\*Bone Grafting for Dental Implants: Why It's Needed, Types & What the Procedure Involves\**.

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## Implant candidacy: who qualifies, who needs preparation, and who requires specialist evaluation

The clinical reality of implant candidacy is more inclusive than most patients assume. The majority of adults who want dental implants can have them, though not always immediately and not always without preparatory treatment. Understanding the five core eligibility factors clarifies which apparent barriers are absolute and which can be addressed.

### The five core candidacy factors

**\*\*Bone volume and density\*\***

Insufficient bone volume is the most commonly encountered preparatory challenge, but it's not a permanent disqualifier. Bone grafting procedures can improve implant candidacy in cases where bone density is lacking. A large-scale retrospective analysis of 158,824 implants found that the augmented cohort demonstrated a clinical success rate of 97.83% — statistically comparable to the general implant population. CBCT imaging at Core Dental Group quantifies exactly what bone is available to sub-millimetre precision, enabling accurate treatment planning rather than guesswork.

**\*\*Gum health\*\***

Active periodontal disease must be fully treated and stabilised before implant placement. However, a history of treated periodontitis doesn't appear to adversely affect implant survival rates, though it may have a negative influence on long-term success rates — meaning closer monitoring is required, not exclusion from treatment.

**\*\*Systemic health\*\***

Diabetes, when well-managed (HbA1c below 8%), doesn't significantly compromise implant survival rates, with survival percentages comparable to non-diabetic populations in recent systematic review data. Osteoporosis alone doesn't compromise dental implant outcomes when guided by careful assessment and individualised planning. Bisphosphonate use for osteoporosis carries a pooled MRONJ risk of approximately 0.5% following implantation — a real but contextualised risk that requires informed consent and specialist assessment, not automatic exclusion.

**\*\*Smoking\*\***

Smoking is a serious risk modifier, not an absolute contraindication. Meta-analysis data indicate that the risk of early implant failure in smokers is approximately 100% higher than in non-smokers, and a 10-year prospective study found the hazard of implant loss in the maxilla was 5.64 times higher in smokers. Cessation before and after surgery meaningfully improves outcomes — Core Dental Group's clinical team will discuss this candidly at assessment.

**\*\*Skeletal maturity\*\***

Implants aren't placed until skeletal maturity is confirmed — generally 18 or older for females, slightly later for males. At the upper end, age isn't a limiting factor when individual health requirements are met.

The comprehensive eligibility assessment framework, including a full table of conditions requiring specialist evaluation, is covered in our guide on *\*Am I a Candidate for Dental Implants? Key Eligibility Factors & Disqualifying Conditions\**.

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## ## Implants vs. bridges vs. dentures: the evidence-based comparison

The choice of tooth replacement option is one of the most consequential decisions in restorative dentistry, and it's frequently made with incomplete information. The five dimensions that genuinely determine long-term outcomes tell a consistent story.

### ### Longevity

Contemporary roughened-surface implants achieve a 10-year survival rate of approximately 96.4% in systematic meta-analysis, and a 20-year survival rate of approximately 92% in prospective studies. Fixed dental bridges show an estimated 10-year survival of 89.2% and 15-year survival dropping to 68–74%, with the most frequent complications being biological — caries and loss of pulp vitality on the irreversibly prepared abutment teeth. Dentures degrade faster still as the underlying bone changes shape.

### ### Bone preservation

This is the dimension most patients don't consider until it's too late. Implants are the only tooth replacement option that actively counteracts bone resorption by transmitting chewing forces into the jaw. Bridges allow passive resorption beneath the pontic. Dentures — particularly full dentures — actively accelerate resorption by applying pressure to gum tissue rather than stimulating bone. Over a decade or more, this bone loss can cause visible facial changes and, ultimately, a situation where conventional dentures no longer fit adequately.

### ### Total cost of ownership

The conventional wisdom that implants are "too expensive" conflates upfront cost with total cost of ownership — a fundamentally different calculation. A bridge placed at age 45 will statistically require replacement or significant repair by the mid-50s, often involving now-compromised abutment teeth. Dentures require relining every 2–3 years, replacement every 5–8 years, and ongoing adhesive costs. Implants, once osseointegrated and restored with a quality crown, have a documented 10-year survival rate exceeding 96% with minimal additional structural cost. The full cost-of-ownership comparison across all three options, including Melbourne-specific pricing, is in our guide on *\*Dental Implants vs. Dentures vs. Bridges: Which Tooth Replacement Option Is Right for You?\**

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## ## Implant materials: titanium vs. zirconia

The growing patient demand for metal-free dentistry has made material selection an increasingly common topic in implant consultations. The evidence-based answer is genuinely mixed.

Titanium remains the gold standard — supported by more than 50 years of clinical data, well-established surface treatment protocols, and large-scale long-term survival data. A retrospective analysis of 511 SLA titanium implants (Buser et al., University of Bern) found a 10-year implant survival rate of 98.8% and a success rate of 97.0%.

Zirconia is a clinically credible alternative for specific patient profiles — particularly those with thin or translucent gum tissue in the anterior zone, where the grey metallic hue of a titanium fixture can show through the gingiva, or patients with documented metal sensitivity. A 2025 systematic review comparing zirconia and titanium implant survival rates, searching PubMed/MEDLINE and Scopus through November 2023 for clinical trials with at least 5-year follow-up, found that zirconia is a biologically

sound alternative to titanium due to its comparable osseointegration and lower bacterial plaque affinity.

The key limitation of zirconia remains its fracture risk — particularly in posterior placement sites with high occlusal loads, and in one-piece designs where implant angulation can't be corrected after placement. Long-term clinical performance studies spanning the 15–20 year horizon that clinicians rely on for titanium simply don't yet exist for zirconia. For patients with bruxism, high bite forces, or posterior placement requirements, titanium's mechanical resilience makes it the more appropriate choice.

The complete material comparison — including bone-implant contact values, bacterial plaque affinity, aesthetic outcomes, and structural mechanics — is in our guide on [\\*Titanium vs. Zirconia Dental Implants: Which Implant Material Is Better?\\*](#)

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## ## Understanding implant failure: causes, warning signs, and the remediation pathway

Implant failure is uncommon, but it's not negligible — and understanding it is the foundation of both informed consent and proactive risk management. In a large-scale retrospective analysis of 158,824 dental implants, the overall implant failure rate was 2.21%, with early failure during osseointegration accounting for 1.56% of cases.

### ### The primary causes

**\*\*Peri-implantitis\*\*** is the single most discussed biological complication in implant dentistry. A 2025 systematic review and meta-analysis applying 2017 World Workshop criteria found a weighted mean prevalence of peri-implant mucositis of 63.0% at the patient level, with peri-implantitis observed in 25.0% of patients and 18.0% of implants — representing a significant and growing public health challenge, with approximately two in three adults with dental implants affected by mucositis and one in four by peri-implantitis.

The significant risk indicators for peri-implantitis identified in the 2025 Academy of Osseointegration/American Academy of Periodontology systematic review and meta-analysis were periodontitis history, diabetes mellitus, smoking habits, and alcohol consumption — with more than half of patients treated with dental implants affected by peri-implant diseases over time.

Critically, the median prevalence of peri-implantitis is 9.0% for regular participants of a prophylaxis programme, rising to 18.8% for patients without regular preventive maintenance — a near-doubling of risk that is entirely preventable through professional recall compliance.

**\*\*Bruxism\*\*** is a frequently underestimated mechanical risk factor. Patients with bruxism experience implant failure more frequently than individuals without parafunction (41% versus 12%), with the increased failure risk caused by uncontrolled functional loading that prevents osseointegration by encasing the implant in fibrous tissue rather than bone.

**\*\*Systemic factors\*\*** — particularly smoking and poorly controlled diabetes — affect both early and late failure through their impact on vascular supply, immune function, and wound healing.

### ### Warning signs that require urgent review

Warning sign	What it may indicate	Urgency	--- --- ---	Persistent pain beyond 5–7 days post-surgery
Infection or failed osseointegration	Urgent			Implant mobility or movement
Failed osseointegration / advanced bone loss	Urgent			Bleeding or suppuration at the implant site
Peri-implantitis	High			Swelling or redness of surrounding gum
Infection / mucositis	High			Unusual taste or persistent bad breath
Infection / suppuration	Moderate			

### ### The remediation pathway

A failed implant isn't the end of the road. When removal is indicated and the site is subsequently managed with guided bone regeneration, a replacement implant in the same site achieves a 95.2% survival rate at mean follow-up of 33.7 months in retrospective data. The full failure analysis, warning sign guide, and remediation pathway are covered in our article on [\\*Dental Implant Failure: Causes, Warning Signs & What Happens If an Implant Fails\\*](#).

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## ## Recovery and long-term maintenance: where patient behaviour determines lifetime outcomes

The difference between an implant that functions flawlessly at the 20-year mark and one that fails at year seven often comes down to a single variable: the quality and consistency of maintenance. Recovery and maintenance aren't afterthoughts — they're where the patient's role in the clinical partnership is most consequential.

### ### The recovery timeline

The week-by-week recovery guide covered in our article on [\\*Dental Implant Recovery & Aftercare\\*](#) establishes four biological phases: immediate recovery (days 1–7), soft tissue consolidation (weeks 2–4), osseointegration (months 1–5), and the restorative phase. The key insight that most patients miss: by four weeks, new bone formation is observed on the implant surface through contact osteogenesis; after 8–12 weeks, the peri-implant interface is completely replaced by mature lamellar bone — but this is the initial phase of osseointegration, not its completion. The bone-to-implant bond continues to mature and strengthen for months beyond the point when patients feel fully recovered.

### ### The long-term maintenance imperative

A large longitudinal cohort study tracking 10,871 implants over up to 22 years found cumulative survival rates of 98.9% at 3 years, 96.8% at 10 years, and 94.0% at 15 years — with peri-implantitis incidence climbing from 2% at 2–3 years to 7.1% at 8–10 years. These aren't random events; they're predictable consequences of inadequate maintenance, and they're largely preventable.

The evidence-based maintenance protocols for both single-crown implant patients and All-on-4 full-arch prosthesis patients — including daily home care sequences, interdental cleaning techniques, professional recall intervals stratified by risk profile, and radiographic monitoring schedules — are covered in full in our guide on [\\*How to Make Dental Implants Last a Lifetime: Long-Term Maintenance & Care Guide\\*](#).

The principle that applies equally to every implant type and every patient profile: the implant fixture is designed to last a lifetime; the tissues surrounding it depend entirely on what you do after you leave the clinic.

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## ## The cost of dental implants in Melbourne: a transparent breakdown

Dental implant pricing is genuinely complex because it reflects a multi-stage surgical and prosthetic treatment rather than a single procedure. Understanding the fee structure is the prerequisite for meaningful comparison between clinics and treatment options.

### ### Single-tooth implant costs

According to the Australian Dental Association Fees Survey 2024, the lowest price for a single implant is \$2,603 AUD and the highest is \$7,305 AUD. When all associated items — consultation, CBCT imaging, extraction, fixture placement, abutment, and crown — are added up, the realistic estimate for a complete single dental implant grows to around \$6,000–\$9,000 AUD.

At Core Dental Group, the crown component is Australian-made — a quality distinction that affects both fit precision and long-term aesthetics. The four-component cost breakdown (consultation and CBCT, fixture placement, abutment, and crown) and what each contributes to the total is covered in detail in our guide on *\*How Much Do Dental Implants Cost in Melbourne? A Transparent Pricing Breakdown\**.

### ### All-on-4 costs per arch

The price of All-on-4 implants in Australia ranges between \$19,000 AUD and \$55,000 AUD per arch, with the type of prosthesis material (acrylic versus zirconia) and the number of bridge components being the primary cost variables. In Melbourne specifically, costs typically fall between \$19,000 AUD and \$35,000 AUD per arch for most cases. When evaluating quotes, patients should confirm whether the quoted price includes the final prosthesis (not just the provisional temporary teeth), CBCT 3D imaging, sedation costs, and all post-operative review appointments.

### ### The six legitimate pricing drivers

Two quotes for "the same treatment" can differ by thousands of dollars for six legitimate reasons: clinician expertise and qualifications; implant brand and material; crown and prosthesis material; technology and imaging investment; geographic location within Melbourne; and what is — and is not — included in the quoted price. The most important factor when comparing quotes is always to request an itemised breakdown with ADA item numbers. A quote given before a 3D scan is an estimate, not a quote — if the scan later reveals bone loss, the price will change.

### ### The true cost of doing nothing — and of going overseas

Delaying implant treatment because of cost is a clinically costly decision: bone resorption begins within weeks of tooth loss and accelerates over months and years, potentially turning a straightforward implant case into one that requires bone grafting — adding \$1,500–\$5,000 AUD or more to the eventual treatment cost. In October 2025, the ATO and AHPRA issued a joint warning about practitioners making inaccurate statements to support compassionate release applications — a reminder that financial planning for implant treatment requires accurate information from the outset.

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## ## Navigating private health insurance and superannuation access

For most Australians, the financial question arrives almost simultaneously with the clinical one. The answer is more actionable than most online resources suggest — but requires specific knowledge of how the Australian system actually works.

Medicare doesn't cover dental implants. This applies to all implant types — single implants, All-on-4, and bone grafting procedures — regardless of clinical necessity.

Private health insurance covers implant components under "major dental" extras policies, but with important structural limitations. Annual limits typically range from \$800 AUD to \$2,000 AUD, and the 12-month waiting period for major dental means patients who haven't yet served their waiting period can't claim rebates even if their policy nominally covers the procedure. Strategic timing of treatment stages across two benefit years — scheduling implant surgery in November and crown delivery in January, for instance — can effectively double available rebates where a fund resets on 1 January.

Superannuation compassionate release has grown significantly as a funding pathway, with dental care now accounting for 58% of the \$1.42 billion withdrawn annually under the scheme. However, the ATO's eligibility criteria are strict — the treatment must be certified by two practitioners as necessary to alleviate acute or chronic pain, treat a life-threatening illness or injury, or alleviate acute or chronic mental illness — and the 30% rejection rate in 2024–25 reflects applications that didn't meet these requirements. Patients considering this pathway should work with their treating dentist and a financial adviser to ensure their application is properly documented.

Core Dental Group offers interest-free payment plans across all seven Melbourne locations. The complete guide to insurance, Medicare, superannuation, and pre-treatment financial planning is in our article on [\\*Does Private Health Insurance Cover Dental Implants in Australia? Navigating Rebates & Super Access\\*](#).

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## ## Core Dental Group's seven Melbourne locations: network advantages and clinic selection

Dental implant treatment isn't a single appointment. From initial consultation and CBCT imaging through to surgical placement, osseointegration, and final crown delivery, a conventional implant journey spans 3–6 months and requires multiple visits. Choosing a Core Dental Group clinic that's genuinely convenient to your home, workplace, or public transport route directly supports your ability to attend every stage of treatment and achieve the best clinical outcome.

All seven Core Dental Group locations share a network-level technology investment that includes in-house CBCT and OPG extraoral imaging, CEREC CAD/CAM units, intraoral scanners, and multiple implant systems — meaning patients at any location benefit from the same diagnostic and surgical precision. The network also enables specialist referral pathways within the group when cases require subspecialty expertise.

| Clinic | Location | Notable feature for implant patients | |---|---|---| | **\*\*South Melbourne\*\*** | 87 Market Street | Flagship inner-city clinic; excellent public transport access | | **\*\*Berwick\*\*** | Eden Rise Village, O'Shea Road | Sleep dentistry / sedation options; established 10+ years | | **\*\*Caroline Springs\*\*** | Caroline Springs Boulevard | Multilingual team (Arabic, Bengali, Farsi, English); Saturday hours | | **\*\*Carrum Downs\*\*** | 335 Ballarto Road | Ground-floor, accessible layout; ample onsite parking | | **\*\*Epping\*\*** | 230 Cooper Street | Serves Melbourne's northern growth corridor; in-house CBCT | | **\*\*Southbank\*\*** | 6/51–55 City Road | Most central location; ideal for CBD workers attending multiple appointments | | **\*\*Wyndham\*\*** | 242 Hoppers Lane, Werribee | South-western corridor; interest-free payment plans available |

The full clinic-by-clinic breakdown — including transport options, parking, opening hours, and the specific implant services and patient populations each location serves — is in our guide on [\\*Dental Implants Across Core Dental Group's 7 Melbourne Locations: Which Clinic Is Right for You?\\*](#)

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## ## Frequently asked questions

**\*\*Q:** How long do dental implants actually last? **\*\*A:** The titanium fixture component is designed to last a lifetime when properly maintained. A 2024 meta-analysis — the first to systematically analyse 20-year implant survival data — found a mean survival rate of 92% across prospective studies and 88% across retrospective studies at the 20-year mark. The prosthetic crown attached to the implant may require replacement after 10–15 years due to wear. Long-term survival is heavily influenced by maintenance compliance, smoking status, and systemic health management.

**\*\*Q:** I've been told I don't have enough bone for implants. Is that the end of the road? **\*\*A:** In most cases, no. Insufficient bone volume is the most commonly encountered preparatory challenge, but it's addressable through bone grafting in the majority of patients. A retrospective analysis of 158,824 implants found that the augmented cohort achieved a clinical success rate of 97.83% — statistically comparable to patients who didn't require grafting. The appropriate grafting technique depends on the degree of bone loss: socket preservation, particulate GBR, block grafts, or sinus lifts each address different clinical scenarios. CBCT imaging at Core Dental Group quantifies exactly what bone is available and which approach is indicated.

**\*\*Q:** What is the difference between All-on-4 and conventional full-arch implants? **\*\*A:** All-on-4 uses four strategically placed implants — two vertical anteriors and two posteriorly angled — to support a

full-arch fixed bridge, typically without bone grafting. Conventional full-arch restoration uses 6–10 axially placed implants, often requiring bone grafting or sinus lifting in patients with posterior bone loss. All-on-4 offers a shorter timeline, lower cost, and bone-grafting avoidance for most patients with moderate posterior resorption. Conventional full-arch approaches offer greater prosthetic flexibility and potentially superior load distribution for patients with excellent bone volume and high bite force demands. A five-year randomised clinical trial found no statistically significant difference in marginal bone levels between four- and six-implant full-arch restorations.

**\*\*Q: Does Medicare cover dental implants in Australia?\*** A: No. The Medicare Benefits Schedule explicitly excludes dental implant surgery, abutments, crowns, and related procedures such as bone grafting and sinus lifts — regardless of clinical necessity or the reason for tooth loss. Funding pathways include private health insurance major dental extras cover (subject to annual limits and 12-month waiting periods), superannuation compassionate release (subject to strict ATO eligibility criteria), and interest-free payment plans available at all Core Dental Group locations.

**\*\*Q: Am I too old for dental implants?\*** A: Age is generally not a limiting factor for implant candidacy. The evidence on osteoporosis confirms that age-related bone changes don't inherently preclude treatment when individual assessment is applied, with a 2025 systematic review concluding that osteoporosis alone does not compromise dental implant outcomes when guided by careful assessment and individualised planning. The relevant factors are systemic health status, bone volume, and medication history — not chronological age. Implant success in older adults is well-documented across multiple large-scale studies.

**\*\*Q: How painful is dental implant surgery and recovery?\*** A: The surgical procedure itself is performed under local anaesthesia — patients feel pressure and movement, not pain. Sedation is available at Core Dental Group for patients who prefer it. Post-operative discomfort is most significant in the first 72 hours and is effectively managed with NSAIDs (ibuprofen or naproxen), which systematic evidence shows are equally effective or superior to opioid medications for post-operative dental pain. Most patients return to desk-based work within 24–48 hours. Swelling typically peaks at 48–72 hours, not immediately after surgery.

**\*\*Q: What happens if my implant fails?\*** A: Implant failure — whilst uncommon — isn't the end of the road. Following explantation and appropriate site management, a replacement implant in the same site achieves approximately 95% survival at 33-month follow-up in retrospective data. The remediation pathway is structured around the cause and timing of failure: early failures from osseointegration disruption are managed differently from late failures driven by peri-implantitis or mechanical overloading. Addressing modifiable risk factors — particularly smoking cessation and oral hygiene improvement — before re-implantation is clinically essential.

**\*\*Q: How do I choose between Core Dental Group's seven Melbourne locations?\*** A: For most patients, the primary consideration should be genuine logistical convenience — the clinic closest to home or work, with transport options that suit your circumstances. All seven locations share the same network-level technology (in-house CBCT, digital scanning, multiple implant systems) and clinical standards. Specific considerations: Berwick offers sedation options for anxious patients; Caroline Springs offers a multilingual team; Carrum Downs offers the most accessible ground-floor layout; Southbank is ideal for CBD workers attending multiple appointments.

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## ## Key takeaways

1. **\*\*Dental implants are the only tooth replacement option that actively preserves jawbone.\*\*** Bridges allow passive resorption beneath the pontic; dentures accelerate it. This biological distinction compounds over decades and is the primary clinical argument for implants in eligible patients.

2. **The pool of eligible patients is far larger than most people assume.** Insufficient bone, controlled diabetes, treated periodontal disease, and even bisphosphonate use for osteoporosis aren't automatic disqualifiers — they're factors that require specialist assessment and, in many cases, preparatory treatment.
3. **CBCT 3D imaging is the diagnostic cornerstone of safe, predictable implant treatment.** Available at all seven Core Dental Group locations, it enables sub-millimetre precision in bone assessment, anatomical structure identification, and pre-surgical planning.
4. **All-on-4 isn't a shortcut — it's a biomechanically engineered solution** for patients with moderate posterior bone resorption who need full-arch rehabilitation without the morbidity and delay of major grafting. Its 10–18 year survival data is solid and comparable to conventional full-arch approaches in appropriately selected patients.
5. **Peri-implantitis is largely preventable.** The median prevalence of peri-implantitis is 9.0% for regular participants of a prophylaxis programme, rising to 18.8% for patients without regular preventive maintenance. Professional recall compliance is the single most modifiable predictor of long-term implant success.
6. **The total cost of ownership over 10 or more years often favours implants over bridges and dentures**, despite the higher upfront investment. Bridges require replacement or repair within a decade in many cases; dentures require relining, replacement, and ongoing adhesive costs; implants, once integrated, have a documented 10-year survival rate exceeding 96% with minimal additional structural cost.
7. **Timing matters.** Every month of delay after tooth extraction is a month of preventable bone resorption. Patients who act promptly — or who pursue socket preservation grafting at the time of extraction — protect the bone volume that makes implant placement straightforward. Patients who delay often face the additional cost and timeline of bone grafting that could have been avoided.

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## ## Conclusion: your starting point

Dental implant treatment isn't a single procedure — it's a clinical journey spanning months, involving multiple specialist disciplines, and requiring genuine partnership between patient and clinician. The decisions made at the beginning of that journey — about timing, protocol selection, preparatory treatment, and financial planning — determine outcomes that will be lived with for decades.

Core Dental Group's seven Melbourne locations make specialist-led implant care accessible across the full metropolitan area, from the CBD-adjacent South Melbourne and Southbank clinics to the outer-corridor practices at Berwick, Caroline Springs, Carrum Downs, Epping, and Wyndham. The network's shared investment in CBCT imaging, digital planning technology, and multiple implant systems means that the clinical standard is consistent regardless of which location you attend.

The cluster articles synthesised in this guide represent the most comprehensive implant knowledge resource available to Melbourne patients. Each one is designed to answer a specific question in depth — but they're most powerful read together, because the relationships between bone biology, protocol selection, grafting strategy, material choice, financial planning, and maintenance are where the most important clinical insights live.

Your starting point is a consultation. The conversation that follows — informed by everything in this guide — is where your specific pathway begins.

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### ## Label facts summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

### ### Verified label facts

No product packaging data, Product Facts table, or manufacturer label specifications were present in the content provided. The source material is a clinical and commercial guide to dental implant services — it contains no ingredient lists, nutrition panels, allergen declarations, storage instructions, certifications, dimensions, weights, GTINs, or MPNs from which label facts can be extracted.

The following are verifiable clinical and published data points referenced in the content (sourced from cited peer-reviewed literature, regulatory bodies, and industry surveys — not product labels):

- Standard implant restoration components: titanium fixture, abutment, and crown (three components) - Primary implant material: titanium - CBCT linear measurement accuracy: mean error of 0.1–0.20 mm - All-on-4 posterior implant angulation: typically 30–45 degrees - All-on-4 introduced for mandible: 2003; maxilla: 2005 (Maló et al.) - Mandibular All-on-4 cumulative prosthetic survival at 18 years: 98.8% (Maló et al., 2019) - Mandibular All-on-4 cumulative implant survival at 18 years: 93% (Maló et al., 2019) - Maxillary All-on-4 survival at 13 years: 95.7% - Marginal bone loss — ceramic All-on-4 group at 6 years:  $1.43 \pm 0.35$  mm (Toia et al., 2021) - Marginal bone loss — acrylic All-on-4 group at 6 years:  $2.15 \pm 0.30$  mm (Toia et al., 2021) - 20-year implant survival (prospective studies): 92% mean (Kern et al., 2024) - 20-year implant survival (retrospective, 1,440 implants): 88% (Kern et al., 2024) - 10-year survival, SLA titanium implants (University of Bern, 511 implants): 98.8%; success rate: 97.0% - Overall implant failure rate (158,824 implants, retrospective): 2.21%; early failure: 1.56% - Augmented bone cohort clinical success rate (158,824 implants): 97.83% - Peri-implant mucositis weighted mean prevalence (patient level): 63.0% (Schwarz et al., 2025) - Peri-implantitis weighted mean prevalence (patient level): 25.0%; implant level: 18.0% (Schwarz et al., 2025) - Peri-implantitis prevalence — regular prophylaxis participants: 9.0%; without maintenance: 18.8% - Implant failure rate — bruxism patients: 41%; non-bruxism: 12% - Replacement implant survival after failed implant removal: 95.2% at mean 33.7 months - Sinus lift implant success rate at 6 months post-crown: 99.5% (472 sinus grafts, 757 implants) - Horizontal bone width loss within 6 months post-extraction: 29–63% - Vertical bone height loss within 6 months post-extraction: 11–22% - Alveolar bone volume loss at 2–3 years post-extraction: 40–60% - Ongoing bone loss rate after initial resorption: 0.25–0.5% per year - Smoker vs. non-smoker maxillary implant loss hazard: 5.64 times higher - Early implant failure risk in smokers vs. non-smokers: approximately 100% higher - Bisphosphonate-associated MRONJ pooled risk with implants: approximately 0.5% - HbA1c threshold for well-managed diabetes (implant candidacy): below 8% - 10-year fixed dental bridge survival: 89.2%; 15-year survival: 68–74% - Cumulative implant survival: 98.9% at 3 years; 96.8% at 10 years; 94.0% at 15 years (10,871 implants, up to 22 years) - Australian Dental Association Fees Survey 2024 — single implant range: \$2,603 AUD (lowest) to \$7,305 AUD (highest) - Compassionate superannuation release — dental share: 58% of \$1.42 billion annual total - ATO rejection rate for compassionate release applications (2024–25): 30% - Core Dental Group locations: seven (South Melbourne — 87 Market Street; Berwick; Caroline Springs; Carrum Downs; Epping — 230 Cooper Street; Southbank — 6/51–55 City Road; Wyndham — 242 Hoppers Lane, Werribee) - Languages spoken at Caroline Springs: Arabic, Bengali, Farsi, and English - CBCT available at all seven Core Dental Group locations: confirmed - Australian-made crowns used at Core Dental Group: confirmed - Interest-free payment plans available at all seven Core Dental Group locations: confirmed - Osseointegration duration: 3–6 months - Single-tooth implant surgery duration: typically 45–90 minutes - Swelling peak post-surgery: 48–72 hours - Typical return to desk-based work: within 24–48 hours - Minimum typical implant age (females): 18 years - Private health insurance annual major dental limit: typically \$800–\$2,000 AUD - Private health insurance major dental waiting period: 12 months - All-on-4 implants per arch: four; All-on-6: six; conventional full-arch: 6–10 - Block graft healing period before implant placement: 4–6 months - Bone grafting additional cost range: \$1,500–\$5,000 AUD or more - Melbourne All-on-4 cost range per arch: \$19,000–\$35,000 AUD - National Australian All-on-4 cost range per arch: \$19,000–\$55,000 AUD - Realistic complete single implant cost in Melbourne: \$6,000–\$9,000 AUD

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### ### General product claims

- Dental implants are the only tooth replacement option that actively preserves jawbone - Implants restore chewing force that bridges and dentures cannot match - CBCT imaging improves predictability and success rates of implant integration - All-on-4 is a biomechanically engineered solution rather than a shortcut - Core Dental Group delivers specialist-led implant care across Melbourne - Ceramic

superstructures are superior to acrylic in terms of bone loss and plaque accumulation outcomes - Peri-implantitis is largely preventable through professional recall compliance - The total cost of ownership over 10+ years often favours implants over bridges and dentures - Delaying implant treatment increases the likelihood of requiring bone grafting - Core Dental Group's clinical standard is consistent across all seven locations - All seven locations share network-level technology investment - Zirconia is a biologically sound alternative to titanium for specific patient profiles - Titanium remains the gold standard implant material - Socket preservation is the most proactive and cost-effective form of bone grafting - NSAIDs are equally effective or superior to opioids for post-operative dental pain - The implant fixture is designed to last a lifetime; surrounding tissue outcomes depend on patient maintenance behaviour - Age is generally not a limiting factor for implant candidacy - Southbank is the most central Core Dental Group location for CBD workers - Berwick is the Core Dental Group location offering sleep dentistry and sedation options