PATIENT CONSENT FOR SURGICAL TREATMENT - Implants insertion

Patient's name and surname, personal identity number ……………………………………

In accordance with Article 32-35 of law, dated December 5th, 1995 about the professions of doctor and dentist (consolidated text Law Gazette from 2008 No. 136 item 857 with subsequent changes) and article 16-18 Act of November 6th, 2008 *Patients' Right and the Commissioner for Patients' Rights,* Law Gazette 2009, No. 52 item 417 with subsequent changes) I agree for surgical treatment - dental implants insertion by the dentist ………………………………………….

I declare that I have answered all the questions carefully and all the answers in survey no. 1 are true. I also declare that I will inform the doctor of any changes in my health. I acknowledge that information mentioned above is confidential. I agree to perform radiological documentation and photography.

I declare that I was informed about:

1. The technique of the treatment and about detailed process of the proposed treatment. I was also informed that treatment will be performed under local anesthesia.

2. I was informed about the fact that the final decision to insert the implants will be taken by the doctor only during surgery, after the unveiling of the alveolar bone. Bone may be unfavorable for the construction of the implant, which can not always be judged on the X-ray.

3. About the risk and possible complications (during or after surgery). Complications that can appear are: swelling, bleeding, inflammation, impaired healing of the surgical wound and consequently expose the intraosseous implant. I was also informed that in case of improper oral hygiene inflammation of soft tissues around the implant, especially inflammation of bones, and as a consequence the implant will have to be removed.

4. About the adverse effects of smoking on the final result of implant treatment.

5. Indications what to do after the surgery, and in particular:
   a. The prohibition to drive for 12 hours after surgery.
   b. the prohibition of drinking alcohol and smoking for at least 10 days after surgery.
   c. the need to take prescribed antibiotics.
   d. the need of rinsing mouth with the recommended mouthwash.
   e. the need of removing stitches.
   f. control visits, at certain dates designated by the doctor.

g. the necessity to conform the oral hygiene.
h. About the costs of the treatment, which I accept.

I have read and understood the rules above. I received all necessary information about my treatment. I declare that I was informed about the alternative methods of treatment , including the discontinuation of treatment. I was informed about the consequences of different methods of treatment and the consequences connected with discontinuation of treatment. I understand that as in case of medical treatments positive effects are not guaranteed. What is more the insertion of implants is conducted to eliminate particular problem and may not eliminate other, hidden problems. This kind of treatment does not protect against caries and periodontal disease.

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Date, Signature and Doctor's stamp   Parent's readable signature

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Readable signature of a patient between 16-18 yo