Polanica-Zdrój, (date) ……………….

PATIENT'S CONSENT TO CONSERVATIVE AND/OR ENDODONTIC TREATMENT

I. PARTICULARS OF THE PATIENT:

First name and surname of the patient: ....
PESEL No.: ....

II. PARTICULARS OF THE SPECIALIST PROVIDING HEALTH SERVICE:

III. DESCRIPTION OF THE PROPOSED HEALTH SERVICE WITH POSSIBLE COMPLICATIONS AND ADVERSE EVENTS:

This form refers to providing the health service:

1. CONSERVATIVE AND ENDODONTIC TREATMENT:

Planned treatment (mark as appropriate)*:

☐ CONSERVATIVE TREATMENT of tooth no. ....
☐ ENDODONTIC TREATMENT of tooth no. ....

Conservative treatment includes the following activities with the following purpose: removal of decayed tooth tissue and its reconstruction with a filling material (tooth reconstruction to restore its primary function). After the filling is made, there may be procedure-related tooth hypersensitivity persisting even for 30 days, temporary sensitivity or gingivitis. If severe caries is diagnosed, it may be necessary to perform endodontic (root canal) treatment. An allergic response to the material/tools used during the treatment process is also possible.

Endodontic (root canal) treatment involves removal of inflamed or non-vital pulp from the inside of the tooth, i.e. the pulp cavity and root canals, followed by permanent filling of this space with therapeutic material - using a microscope. Due to a complex anatomical structure of teeth and surrounding tissues, endodontic treatment is not always possible or may prove unsuccessful in the course of the procedure. In the case of complex, atypical or blocked root canals, as well as for teeth previously treated, the risk of complications is higher. Endodontic retreatment is always more difficult and it may not always be possible to perform it using a conservative and little invasive method. Endodontic retreatment also carries a higher risk of complications and failure. During endodontic treatment, a crown fracture may occur. It is possible that the doctor will have to remove a part of the crown on purpose, in order to effect proper treatment. Perforation of the root canal or bottom of the pulp cavity is also possible. There is a risk of endodontic instrument separation in the root canal (with no possibility of its removal) and pushing the filling material over the canal apex, which may cause pain and, very rarely, eventually necessitate surgical removal of a tooth part. During root canal treatment of a tooth with a prosthetic crown, the crown may be irreversibly damaged or it may be necessary to remove it. During, and especially after endodontic treatment, temporary pain may occur, and, in rare cases, exacerbation of the inflammatory process may develop (spontaneous tooth pain, swelling, serous or purulent exudate, fistula activation), which may require a use of pharmacological agents. An allergic response to the material/tools used during the treatment process is also possible. Endodontic treatment of teeth with periapical lesions carries a higher risk - despite treatment, the lesions may not heal properly (which may decrease the chances of maintenance of a given tooth in the oral cavity). Despite conducted endodontic treatment, a need for surgical procedure may arise (e.g. cutting off the root apex or the whole root) or if this is not successful, it may be necessary to extract the tooth. If the crown is not severely damaged, conservative reconstruction by means of composite material and/or inlay is usually enough. If the tooth is severely damaged, it is necessary to perform prosthetic restoration.

2. ANAESTHESIA:

The above-mentioned health service may be provided under local anaesthesia, performed at the patient's request. **It involves** administration of a pharmacological agent into the tissues of the oral cavity, resulting in blocking the nerves responsible for innervation of a given area. The administration of anaesthesia may cause adverse effects or complications related to individual patient sensitivity. **Common and less dangerous complications include:** sensitivity at the site of insertion, tissue ecchymoma (bruise), swelling, dizziness, biting the lip and cheek, increased blood pressure and heart rate. **Rare complications include:** Syncope, incomplete sensory nerve palsy, infection after injection, allergic response.

3. X-ray/CBCT:

During the examination or when providing the above-mentioned health service, it may be necessary to take an X-ray picture (radiological examination). This is an imaging examination performed with the use of X-ray radiation, which may have a negative effect on the body; that is why, the radiation dose is reduced to a minimum allowing for a technically correct examination result. The examination may involve: an X-ray picture of a given tooth area, pantomographic X-ray picture, or tomographic X-ray picture. **Pregnancy is an absolute contraindication to a radiological examination.** All female patients should inform the doctor about suspected or confirmed pregnancy before an x-ray is taken. All patients should inform the doctor about the fact of their oncological treatment before an x-ray is taken.

Each health service is related to a risk of complications and/or adverse events, even when due care is taken by the personnel rendering the service. We do our best to minimise the risk of their occurrence; nevertheless, no doctor or medical entity can guarantee their complete exclusion. The above include most of possible complications and sequelae. However, it is always possible in the field of medicine that situations yet unreported, related to atypical anatomy or atypical patient's reaction may happen.

Additional comments: ....

IV. PATIENT'S DECLARATION:

I declare that:

1) I am not totally incapacitated;
2) I have provided detailed and true information on my state of health to the best of my knowledge, in accordance with the completed medical history;
3) I will immediately inform the doctor in writing about any changes in my state of health
4) I have been fully informed in an understandable manner about:
   a) my state of health;
   b) essence, manner and purpose of the above-mentioned health service;
   c) In particular, I have been informed that:
      - in the case of missing teeth, their immediate completion is necessary;
      - during endodontic treatment, it is necessary to take several x-ray and/or tomographic pictures;
      - after endodontic treatment, it is necessary to perform permanent tooth reconstruction as soon as possible, due to a high risk of fracture of the impaired crown;
      - the treatment plan may be changed if any unpredicted circumstances occur in the course of treatment, about which the patient will be informed, and if he gives his/her consent;
      - after treatment completion, the patient is required to appear for follow-up visits and prophylactic visits on dates appointed by the doctor, at least every 12 months;

   d) Possible alternative diagnostic and therapeutic procedures, which include:
      ....
      and about risk related to these methods;

   e) possibility to discontinue conservative and endodontic treatment and its consequences;
   f) risk of adverse effects and complications which may occur in the course of conservative and endodontic treatment and after its completion, described in detail in section III of this form;

g) importance of informing the doctor of any worrying symptoms, especially of complications and adverse effects;
h) possibility to ask questions and report concerns to the medical personnel regarding the above-mentioned treatment;

5) I reported all my concerns to the medical personnel and I have asked all the questions that bothered me with regard to the above-mentioned treatment, and I have received understandable explanations and answers;
6) I understand that, similarly to other medical and dental procedures, positive effects of the above-mentioned treatment are not guaranteed;
7) I am aware that I am free to withdraw my consent to the health service at any time:
8) I have read the content of this document, I fully understand it, and I have no reservations in this regard.

V. PATIENT'S CONSENT.

I declare that I give my consent to the following health services:
(Put an X in the appropriate box)*

☐ conservative treatment
☐ endodontic treatment
☐ anaesthesia
☐ X-ray/CBCT

....	....
Date, signature and stamp of the doctor	date and legible signature of the patient

VI. INFORMATION ON THE TERMS AND CONDITIONS OF PROVIDING THE HEALTH SERVICE

1) EXPECTED COST OF TREATMENT: ....
2) TERMS OF PAYMENT: Payment for treatment shall be made after the visit.
3) QUALITY GUARANTEE:

The medical entity grants a 2-year quality guarantee regarding the conservative and/or endodontic treatment under the following conditions:

1. the conditions of exercising the guarantee rights include:
   a. coming for regular control and hygiene visits, which the patient is obliged to complete at the medical facility which provided the health service, on dates appointed by the doctor, at least every 12 months;
   b. patient compliance with all doctor's instructions;
   c. maintaining proper oral hygiene by the patient;

   failure of the patient to fulfil any of the above-mentioned condition will result in the loss of quality guarantee rights - unless the reasons are attributable to the medical entity;

2. the guarantee shall not cover services performed in patients with:
   a. disorders of the masticatory organ,
   b. natural bone atrophy,
   c. periodontal diseases,
   d. unresolved carious lesions and tooth deficits,

   which may have a direct or indirect effect on the durability of the service performed;

3. the guarantee shall not cover:
   a. damages unrelated to the service performed;
   b. the service, if the patient did not comply with the doctor’s instructions;
   c. temporary fillings;
   d. cost of travel to the dental office incurred by the patient.

4. PATIENT DECLARATION.

Acting on behalf of myself, I hereby declare that:

1. I have been informed about the terms and conditions of payment and quality guarantee, and I fully accept them;
2. I acknowledge and accept that the cost of travel to the office is borne by the patient;
3. I understand that in the event of changes to the scope of the health service provided, the amount of the initially estimated cost of treatment (section VI, subsection 1) may change;
4. I am aware that the treatment success and outcomes are highly dependent on my compliance with the doctor's instructions, and I undertake to comply with them, which includes regular control and hygiene visits.

....

(date, patient's signature)

VII.CONSENT TO DISCLOSURE OF MEDICAL CONFIDENTIALITY

Acting on behalf of myself, I hereby declare that I agree to disclosure of medical confidentiality regarding the above-mentioned treatment, including presentation or publication, **in a form preventing my identification ,** X-ray/CBCT pictures and photographic documentation for the following purposes: educating other patients (review of fragments of medical documentation), personnel training, and marketing (information about health services provided). I shall not make any claims in this respect. I am aware that I am free to withdraw my consent at any time, without any negative consequences of this decision.

....

(date, patient's signature)