Polanica-Zdrój, _____

PATIENT`S INFORMED CONSENT FOR SCREW/CEMENT FIXING OF PROSTHETIC RESTORATION

I. PATIENT DATA:

Patient's first name and surname: …….
Personal Identification Number PESEL: …….

II. DETAILS OF THE HEALTHCARE PROFESSIONAL WHO PERFORMS THE PROCEDURE:

III. DESCRIPTION OF THE SCHEDULED MEDICAL PROCEDURE, POSSIBLE COMPLICATIONS AND ADVERSE REACTIONS:

This informed consent form concerns the following medical procedure:

1. SCREW/CEMENT FIXING OF PROSTHETIC RESTORATION:

This informed consent form concerns the following prosthetic restoration:

Method of fixing the prosthetic restoration:

[__] Cement [__] Screws (tick as appropriate)

This treatment involves the following procedures and has the following purpose: the purpose of the visit is to replace missing teeth and to restore normal functions of the masticatory system by fixing (with cement or screws) a prosthetic restoration. Before the prosthetic restoration is fixed, the patient approves the shape, appearance and color of the prosthetic restoration (no changes to the prosthetic restoration are possible thereafter). After cementing/screwing the prosthetic restoration, temporary hypersensitivity or inflammation of the gums may occur, as well as postoperative hypersensitivity of the tooth that may persist for up to 30 days; sometimes analgesic agents may be necessary to relieve these symptoms. If tooth hypersensitivity persists, endodontic (root canal) treatment of the tooth may be necessary. An allergic reaction to the tools/materials used may occur during the treatment.

2. ANESTHESIA:

This medical procedure may be performed under local anesthesia, at the patient's request, in which case a pharmacological agent is administered to the tissue within the oral cavity to block the nerves within the target area. After administration of anesthesia, adverse reactions or complications may occur, depending on the patient's individual sensitivity. **Common but less dangerous complications include**: sensitivity of the injection site, tissue hematoma (bruising), swelling, dizziness, lip and cheek biting, increased blood pressure and increased heart rate. **Rare complications include**: fainting, partial paralysis of the sensory nerve, post-injection infection, allergic reaction.

3. X-ray/CBCT:

It may be necessary to perform an X-ray (radiological examination) during the medical examination or the medical procedure referred to in this form. This is an imaging diagnostic procedure performed using X-rays, which have an adverse effect on the human body; as a result, the dose of radiation is reduced to the minimum necessary to obtain technically correct images (test results). This examination may include: tooth/teeth x-ray in the target area, dental panoramic radiograph, and X-ray tomography. **Radiological examinations are absolutely contraindicated during pregnancy.** If you are a women, please make sure to tell your doctor if you are or may be pregnant before the X-ray. If you are correctly receiving any oncological treatment, please make sure to tell your doctor about it before the X-ray.

Like any other medical procedure, this procedure is also associated with a risk of complications and/or adverse reactions, also if all precautions are followed by the medical staff engaged in this procedure. We make every effort to minimize the risk of any complications and/or adverse reactions; however, their occurrence cannot be ruled out or prevented by any medical professional or healthcare center.

Other remarks: ...

IV. PATIENT'S STATEMENT:

I confirm that:

1) I have not been legally incapacitated;
2) I have provided complete and true information about my health to the best of my knowledge, and in accordance with my medical history;

3) I agree to notify my doctor in writing without delay of any changes in my health status;
4) I have been fully informed in an understandable manner:
a) about my health;
b) about the nature, method and purpose of the medical procedure concerned;
c) in particular, I have been informed that:
• if any other teeth are missing, I need to have them restored without delay;
• the treatment plan may be modified if any unforeseen circumstances arise in the course of treatment; I shall be advised of any such modifications, and I shall be asked for my consent;
• the prosthetic restoration may impede the interpretation of radiological and magnetic resonance images of the head (possible artifacts, resulting in lower accuracy of the radiological images);
• after the treatment is completed, I shall be required to attend follow-up visits and medical check-ups as per the timetable recommended by my doctor, at least every 12 months;
d) I have the right to refuse to consent to this treatment, and I was made aware of the resulting consequences;
e) there is a risk of adverse reactions and complications during and after the cementation/screwing of the prosthetic restoration, which are described in detail in section III of this informed consent form;
f) the importance of reporting any alarming symptoms to my doctor, including any complications and adverse reactions;
g) that I have the right to ask questions and voice concerns about the treatment to the medical staff;
5) I reported to the medical staff all my concerns and asked all my questions concerning the treatment, and I had all my concerns addressed and the questions answered to my satisfaction and in an understandable manner;
6) I understand that, as with any general medical and dental procedures, the positive outcomes of the medical procedure concerned are not guaranteed;
7) I am aware that I can withdraw my consent to this medical procedure at any time;
8) I have read and fully understood this document, and do not report any reservations.

V. PATIENT'S CONSENT

I confirm that I consent to have the following medical procedure:
(please insert an X as appropriate)*

[__] screw/cement fixing of prosthetic restoration:
[__] anesthesia
[__] X-ray/CBCT

I confirm that I accept the shape, appearance and color of the prosthetic restoration. I am aware that, after the prosthetic restoration is cemented/screwed, it cannot be modified.

....
doctor's signature, stamp and date patient's legible signature and date

VI. INFORMATION ON THE CONDITIONS OF DELIVERING HEALTHCARE SERVICES

1) ESTIMATED TREATMENT COSTS: as approved by the patient on the day the prosthetic treatment is initiated
2) PAYMENT CONDITIONS: The outstanding payment shall be payable on the day when the cementing/screwing the prosthetic restoration is performed.
3) QUALITY ASSURANCE:

The healthcare center grants a 2-year service quality assurance for the prosthetic restorations, subject to the following conditions:

1. the service quality assurance conditions include:
a. attending regular check-up and hygienization visits at the healthcare center where the medical procedure has been performed, at the intervals recommended by a healthcare professional, at least every 12 months;
b. patient's compliance with all the recommendations of healthcare professionals;
c. maintaining proper oral hygiene;

non-compliance by the patient with any of the above conditions results in the loss of rights under the service quality assurance, unless for reasons attributable to the healthcare center;

2. the service quality assurance does not cover any medical procedures performed in patients with:
a. masticatory disorders,
b. natural bone loss,
c. periodontal conditions,
d. untreated tooth decay or missing teeth,

conditions that may have a direct or indirect impact on the durability of the healthcare service provided;

3. the service quality assurance does not cover:
a. changes in the aesthetics, shape and color of the fixed prosthetic restoration, which was finally approved by the patient before the cementing/screwing procedure;
b. damage not resulting from reasons inherent in the prosthetic restoration or the healthcare service performed;
c. healthcare services, if the patient failed to comply with the doctor's orders;
d. temporary restoration;
e. travel costs incurred by the patient.

4) PATIENT'S STATEMENT

I hereby confirm that:

1. I have been informed about the terms of payment and quality assurance, which I fully acknowledge and accept;
2. I acknowledge and accept that the costs of travel to/from the healthcare center shall not be reimbursed;
3. I understand that, in the event of a change in the scope of the healthcare service provided, the amount of the pre-determined expected treatment costs (section VI item 1) may be modified accordingly;
4. I am aware that the success and outcomes of the treatment depend to a large extent on my compliance with the doctor's recommendations, which I agree to follow, including by attending regular check-ups and hygienization visits;

.....
(patient's signature and date)

VII.CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Acting on my own behalf, I hereby confirm that I consent to the disclosure of confidential medical information concerning the medical procedure referred to hereinabove, in the form of X-ray/CBCT images and photographs to be presented or published, **without disclosing any personally identifiable information**, for the purposes of: educating other patients (presenting medical records for illustrative purposes only), staff training, and marketing (informing about the health services delivered). I confirm I shall not be entitled to make any claims in this respect. I am aware that I can withdraw my consent at any time, without any negative consequences.

.....
(patient's signature and date)