

PATIENT'S INFORMED CONSENT FOR TOOTH EXTRACTION**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. EXTRACTION (REMOVAL) PROCEDURE:

The scheduled extraction/removal (tick as appropriate) concerns:

 tooth/teeth: ... root/roots: ...

This treatment involves the following procedures and has the following purpose: Extraction is a surgical procedure through which a tooth/teeth or a tooth root/roots is/are irreversible removed using surgical instruments. It may require incision of the gum and periosteum, bone removal (that surrounds the tooth or root) and suturing the incision site after the procedure. It is usually performed when the available methods of conservative treatment prove ineffective or when tooth tissue is damaged to the extent that it cannot be effectively managed or restored. Extraction of a healthy tooth can also be performed to prepare the oral cavity for prosthetic treatment or as part of orthodontic treatment, as well as for prophylactic purposes (removal of wisdom tooth buds and other additional teeth). Extraction may require additional treatment procedures, such as curettage (removal) of an inflammatory lesion surrounding the removed tooth, alignment of bone edges, bone regeneration, or administration of platelet-rich plasma. The removed tissue may require histopathological examination (examination under a microscope for diagnostic purposes). Bone can be regenerated (augmented) by fixing a superstructure over the patient's maxillary or mandibular bone defects.

Regeneration can be carried out using various types of biomaterials: autogenous bone (grafted from the same patient), homogeneous bone (biomaterial from a bone tissue bank collected from other donors), biomaterials of animal origin, and synthetic biomaterials (of organic or inorganic origin). The post-extraction wound is covered with a sterile gauze pad. In some procedures, the tooth sockets are secured with sutures, which should be removed according to the doctor's instructions, usually 5 to 14 days after the procedure. After the extraction, the tooth socket is filled with blood that turns into a clot, facilitating the healing processes and the formation of "bone scars". The clot is essential for proper healing and it should not be removed. The discomfort usually subsides within three days to two weeks. Sometimes the extraction procedure requires the use of pharmacotherapy (before, during or after the procedure). There may also be an allergic reaction to the materials/tools used during the procedure. In very complicated cases, where there is a high risk that the procedure will prove unsuccessful, the healthcare professional may refuse to perform it and refer the patient to other specialist healthcare professionals.

Possible complications:

Surgical treatment is also associated with the risk of complications, including swelling, bleeding, bruising, pain, inflammation, prolonged wound healing, which can lead to the development of a "dry socket" (difficult healing due to loss of blood clot), nerve damage, sensory disorders, perforation of the sinus floor, openings between the mouth and main sinus, trismus, damage to adjacent teeth.

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. Anesthesia eliminates pain, but the sensation of touch, pressure or expansion is preserved.

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) about the technique of the procedure and I have been extensively advised about the course of the treatment;
 - d) that I need to follow post-treatment medical recommendations, specifically the oral hygiene recommendations (recommendations will be issued to the patient in writing);
 - e) that I need to use pharmacotherapy recommended by my doctor;
 - f) in particular, I have been informed that:
 - unless oral hygiene is correctly maintained, tissue inflammation may occur, which may require additional treatment;
 - 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;
 - smoking has an adverse effect on the wound healing process;
 - 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,
 - g) I have the right to refuse to consent to this surgical treatment, and I was made aware of the resulting consequences;
 - h) there is a risk of adverse reactions and complications during and after the surgical treatment, which are described in detail in section III of this informed consent form;
 - i) the importance of reporting any alarming symptoms to my doctor, including any complications and adverse reactions;
 - j) 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)*

- extraction (removal)
 bone regeneration using: ...
 anesthesia
 X-ray/CBCT

.....
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: ____

- 2) PAYMENT CONDITIONS: Payment will be made after the surgical treatment is performed.

- 3) 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)