Consent Form: Surgical procedure / Tooth extraction / Apicectomy

Name of patient: _____
Last Name First Name Father's Name I.D.

I declare and confirm that I received detailed verbal explanation from:
Dr. _____
Last name First Name
regarding the need for surgical treatment / tooth extraction / apicectomy (root-end removal): _____
_____ (Hereinafter: the "Principal Treatment").
Details of the treatment

I was informed of the anticipated results, the possible treatment alternatives under the circumstances of the case, as well as of the consequences of lack of treatment. The alternative treatments were considered by me before choosing this treatment.

It was explained to me that smoking, untreated gum disease and diabetes significantly heighten the risk of complications and risks. I was also informed of the importance of quitting smoking before and after treatment, of treating gum disease and of balancing diabetes It was further explained to me that undergoing a surgical treatment while taking medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma, especially the use of steroids, smoking and diabetes, heighten the risk of chronic inflammation and even necrosis of the jaw bones.

I also received explanation concerning the side effects of the Principal Treatment, including significant swelling, pain, subcutaneous hematoma and temporary limitation in mouth opening.

I was also informed of the risks and complications of the Principal Treatment including infection, injury of any of the facial nerves, which means temporary or permanent loss of sensation, possible injury to the sinus in the upper (maxillary) jaw and in rare cases, fracture of the jaw bone.

It was explained to me that the manner and duration of recovery of the bone and gums following surgery are individual and unpredictable. It was also clarified to me that part of the complications would require further treatment.

I am aware and I understand the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff/doctor, including maintaining oral hygiene and attending follow-up checkups on schedule, as required.

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after being informed of the risks and complications of anesthesia including sensation disorder in the lip and/or tongue and/or chin and/or face, subcutaneous hemorrhage, swelling and limitation in mouth opening. Should it be decided to perform the Principal Treatment under general anesthesia or under intravenous sedation, the anesthetic technique would be explained to me by an anesthesiologist.

_____
Date Patient's Signature

_____
Name of Guardian (relationship) Guardian's signature
(when patient is legally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____
Name of Physician Signature License No