# 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.
**I was also informed** of the importance of quitting smoking before and after treatment, of treating gum disease and of balancing diabetes. It was explained to me that smoking, untreated gum disease and diabetes significantly heighten the risk of complications and risks. It was further explained to me that the combination of surgical treatment and bisphosphonate medications, whether at present or in the past (medications used for treatment of osteoporosis and/or bone diseases and/or use of steroids), 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 in the affected site, possible injury to the sinus in the upper jaw (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.

MRM
The Medical Risk Management Company