HappySmile
GABINET STOMATOLOGII I MEDYCYNY ESTETYCZNEJ

CONSENT TO SURGICAL TREATMENT

Patient's name and surname, PESEL number .....

Pursuant to Articles 32-35 of the Act of December 5, 1996, on the professions of physicians and dentists (consolidated text: Journal of Laws of 2008, No. 136, item 857, as amended) and Articles 16-18 of the Act of November 6, 2008, on patients' rights and the Patient Ombudsman (Journal of Laws of 2009, No. 52, item 417, as amended), I consent to treatment in the field of dental surgery at the HappySmile Dentistry and Aesthetic Medicine Clinic.
I declare that I have provided comprehensive and truthful information regarding my health – in accordance with the questionnaire constituting Appendix 1 to this declaration. I undertake to notify my treating physician of any changes in my health. I acknowledge that the above information is confidential. I consent to the collection of radiological and photographic documentation.

I have been informed:
1. About the procedure technique and the entire course of the proposed treatment, as well as that the procedure will be performed under local or general anesthesia.

2. About the risks and possible complications (during or after the procedure), such as swelling, bleeding, inflammation, and impaired healing of the surgical wound. That insufficient oral hygiene may lead to tissue inflammation, particularly bone inflammation, and consequently, the need for additional treatment and surgical procedures.

3. About the adverse effects of smoking on the final outcome of wound healing.

4. About the instructions for post-procedure care, in particular:
a) prohibition of strenuous physical activity
b) prohibition of driving for 12 hours after the procedure
c) prohibition of drinking alcohol and smoking for at least 7 days after the procedure
d) the patient must take the prescribed antibiotic
e) the patient must rinse their mouth with the prescribed antiseptic
f) the patient must remove surgical sutures
g) follow-up appointments, which the patient must attend at the times designated by the doctor
h) the patient must strictly adhere to oral hygiene recommendations

5. About the costs of the treatment, which I accept (excluding benefits covered by the National Health Fund)

I have read and understood the above rules and have received all explanations regarding my treatment. I have been informed about alternative treatment options, including the option of discontinuing treatment. I have been informed about the risks associated with other treatment methods and the consequences of discontinuing treatment. I understand that, as with all general medical procedures, positive treatment results are not guaranteed. Furthermore, the surgical procedure is performed to correct a specific problem and may not eliminate other underlying issues. I understand that I may withdraw consent to treatment.

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Date, signature, and dentist's stamp

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Legible signature of patient (Parent or guardian)