Stamp of health care unit

place, date

Dental Implant Placement Consent Form

Patient:

name and surname: _____

residential address: _____

PESEL/ID: _____

tel.: _____

e-mail: _____

Dental Office/Health Facility:

name of unit _____

address: _____

NIP/tax number: _____

tel.: _____

e-mail: _____

Details of attending dentist: _____

Type of consent

(put an "X" in the appropriate box together with the legible signature of the persons authorised according to the particular type of consent given)

☐ **Patient's Own Consent**

Consent given by the Patient him/herself in his/her own name _____

legible signature of Patient

☐ **Surrogate Consent**

Consent given in cases where the Patient is a minor (up to 16 years of age) or is incapable of consciously giving consent (is incapacitated) and unable to make independent decisions regarding his/her treatment. In such cases consent may be given by a statutory representative or court-appointed guardian.

_____

legible signature of guardian

☐ **Parallel Consent**

Such consent is given simultaneously by the Patient and a statutory representative or court-appointed guardian in cases where the Patient is 16 years old or is incapacitated, but still capable of making conscious decisions regarding the health treatment he or she may receive.

_____ _____

legible signature of Patient and guardian/custodian

Details of parent, guardian/custodian * in the case of Surrogate or Parallel Consent.

address: _____
PESEL/ID _____
tel. _____
e-mail _____
relationship to Patient: _____

Note: In the case of "Relationship to Patient" please provide documentary proof that you are responsible for the patient's care as well as the number and name of the appropriate documents:

- if you are the Patient's parent – proof of identity of the Patient (child) and of you as the parent
- if you are a guardian/custodian – proof of identity of the Patient and of you as the guardian/custodian as well as the court decision awarding custody to you as a guardian/custodian.

Declaration of patient/guardian/custodian*.

I declare that I have not been deprived of or restricted in my parental* rights to exercise care, my custody rights* over: (enter first name and last name of the Patient) _____

* - delete where not applicable

_____

*legible signature of parent/guardian/custodian**

Recommended scope of procedure:

Recommended implant placement site (amount of implants):

_____

Cosmetic features in aesthetic zone:

_____

Planned scope of procedure accepted by Patient:

Planned implant type:

_____

Planned implant placement site:

_____

Additional arrangements:

_____

_____

_____

Additional arrangements – prosthetics:

_____

_____

_____

In the case of differences between the recommended and planned (accepted by Patient) scope of the procedure. I declare that I have been informed of all the possible circumstances and risks arising from my refusal to consent to the recommended treatment.

legible signature of Patient or legal representative

Pursuant to Articles 32 – 35 of the Act of 5 December 1996 on the Professions of Doctor and Dentist (consolidated text Journal of Laws of 2008 No 136 item 857 as amended) and Articles 16 -18 of the Act of 6 November 2008 on Patients' Rights and the Commissioner for Patients' Rights (Journal of Laws of 2009 No 52 item 417 as amended), I consent to implantation of oral implants, to the extent determined above, in this clinic.

legible signature of Patient or legal representative

I consent to performance of the tests which are necessary before the implant surgery, i.e.

legible signature of Patient or legal representative

I declare that I was advised of any circumstances and risk connected with the refusal to consent to recommended services, inclusive of the cessation of treatment.

legible signature of Patient or legal representative

signature of attending dentist – accepting declaration of Patient

Declaration of Patient

I declare the following:

1. On the day _____ an informational interview was conducted with me (with my legal representative) regarding the placement of implants or bone substitute materials. During this interview various implant systems were discussed with me with regard to their suitability in a given individual case.

2. With the help of information materials, X-rays and photographs of earlier treated cases and possible treatment ideas I was provided with all possible information regarding the scope and course of the planned treatment. I was also informed in a clear and understandable way of any possible side effects and risks.

3. After being informed of other conventional methods of treatment, such as prosthetic solutions, and after having considered all the information that is important for my case and being also made aware of all the possible complications I have decided to undergo the procedure.

    a) I was informed about the risk accompanying other treatment methods and the consequences resulting from cessation of treatment. I understand that, like in the case of all general medical procedures, positive treatment effects are not guaranteed. In addition, the purpose of the surgery is to remove a specific problem and may not eliminate other hidden problems. I know that I can withdraw my consent to the treatment.

4. I have been notified of cases in which complications have led to the loss of an implant. I have been notified that neither the doctor nor the health facility can guarantee the expected treatment outcome, which depends on many factors, including the personal characteristics of the Patient, the Patient's health, the diseases he/she has had as well as the conduct of the Patient following the procedure. It has been explained to me that although the proposed treatment has been carried out successfully for many years, it does not guarantee that the implants will remain in place indefinitely. It is not possible to determine on the basis of modern diagnostic methods the potential healing ability of bone and gum tissue. In a small percentage of cases the implants may, for various reasons, be gradually lost.

5. I declare that I was informed in a clear and understandable way of the following:
    a) the state of my health and my diagnosis,
    b) suggested as well as possible diagnostic and treatment methods,
    c) the expected consequences of applying these methods or not applying them,
    d) the results of the treatment and prognosis,
    e) all the circumstances connected with the planned medical treatment and care.
    f) the effects and risks of refusing to consent to the treatment.

6. If I (the Patient) do not understand the information I receive from the physician or medical personnel I undertake to inform the attending dentist of the fact that I have not understood and to notify of the fact in writing the head of the facility, i.e. this Health Facility.

7. I declare that if I wish or request that the physician seeks the opinion of an appropriate specialist or holds a case conference, I shall do so in writing.

8. I have been informed that additional tests will be necessary following the procedure, and also that the physician has given me instructions regarding my conduct following the procedure and I also declare that I have received in writing the following instructions: "Information on how I should conduct myself following implant treatment, augmentation and sinus lifting".

9. Aware as I am of all possible complications, even in the case of the failure of the procedure and the loss of the implant, I shall not pursue a claim against the physician who conducted the procedure, nor against the medical establishment in which the procedure took place for any damages nor for the reimbursement of the costs if the expected results are not achieved. Regardless of the above the Patient does not waive his/her right to pursue a claim for any possible personal or material harm on the basis of the ordinary (non-extended) civil liability of the physician or health facility.

10. I am aware that my general state of health has an effect on the implant treatment and I thus declare that I have disclosed in full all known complications and illnesses in my medical history, as well as any medicines I am currently taking. I declare that I provided exhaustive and true information regarding my health. I agree to inform the attending physician about any changes related to my health. I acknowledge that a/m data are confidential.

11. I understand that the final outcome and durability of the treatment largely depend on the conduct of the Patient during the post-operative period and afterwards, and in particular on the following:

    a) refraining from smoking cigarettes, which has a very negative impact on the healing process, since smoking is a relative contraindication for implant-prosthetic treatment.
    b) undergoing periodic check-ups, i.e. in the first month after the completed treatment, and then once every six months, is an essential requirement in treatment process;
    c) rigorously observing instructions on maintaining proper oral hygiene.
    d) I agree to comply with any medical recommendations, in particular those relating to oral hygiene and to come for checkups on fixed dates

12. I have been informed that the prosthetic and post-operative surgical phases of the second stage of treatment following the operation must be performed in the Dental Office where the implant placement took place. In any other case the Dental Office in which the implantation took place shall not assume responsibility for the further course of the treatment.

13. I am aware that it may become necessary during the operation to change the direction of the procedure (widen or reduce its scope) and I hereby give my consent for any necessary changes to thus be made, and I shall cover the costs if the procedure is widened in scope according to the price list attached.

14. I have been notified beforehand that the implants need 4-7 months to integrate with the bone. If the need arises during this time to remove the implants **I declare that I have been informed of the conditions and costs of renewed implant placement.**

15. I hereby give my consent for the above medical treatment to be performed by the attending dentist as well as by any other physician or medical Staff member (in accordance with his/her qualifications) of the said Health Facility. I have been informed and I accept that the "physicians and medical personnel of this Health Facility" refers to all persons providing health care and treatment on the premises of this Health Facility with the consent of the head of the facility, regardless of the form of employment or co-operation.

16. I give my consent for interns or other physicians or personnel to be present for teaching purposes during my (the Patient's) course of treatment on condition that they are there with the consent of the head of the Facility.

17. I declare that I have been given access to information regarding the rights of the Patient – on the information board.

18. I declare that I hereby give my consent for my (the Patient's) health records to be kept on the premises of this Health Facility as well as for any doctors and medical personnel of this Health Facility to inspect this documentation.

19. I declare that I understand and accept the conditions for leaving/placing outer clothing in the waiting room, which is a public place. I have been notified and I accept that the physicians and personnel of the Health Facility are concerned with, and are focused on, providing health care and treatment. Hence, neither physicians nor personnel can take care of clothing or other items left in the waiting room. In connection with the above:
    a) No briefcases, bags, handbags, documents, cash, other valuables, credit cards, jewellery, keys to vehicles or flats or other similar items shall be left in the waiting room without my supervision.
    b) If the above mentioned items or outerwear must be safeguarded against loss while I am receiving medical treatment I (the Patient) must inform the physician or a member of the medical staff of the above-mentioned items and entrust them with the task of storing the above-mentioned items in a room separate from the waiting room or in a closed locker.
    c) I waive any claims against the Health Facility for any loss of clothing or other items resulting from my failure to comply with the above-mentioned points.

I declare that I fully understand the above declarations and I make them in accordance with the facts. I have no reservations or comments.

I am aware of the benefits and possible complications and I give my consent for the procedure to be carried out within the above-mentioned scope.

Enclosures:
1) Information regarding the Patient's conduct following implant treatment, augmentation and sinus lifting.
2) Information regarding problems and issues connected with implant procedure that have been explained to the Patient;
3) Contract to perform the placement of dental implants;
4) Price list

_____
legible signature of Patient or legal representative

I agree that any information about my health, diagnosis, proposed and possible diagnostic and treatment methods, foreseeable after effects of the application or abandonment thereof, treatment results and prognosis can be provided to other persons, i.e. _____

_____

_____
legible signature of Patient

I hereby consent for my personal data contained in the "Consent of the Patient" form as well as data on my health, photographs and medical documentation to be processed now and in the future (in accordance with the Personal Data Protection Act of 29.08.1997, Dz. Ust. [*Journal of Laws*] No. 133, item 883 with later amendments) for the needs of performing medical procedures and planning and supporting future and current agreements/treatment, which I am receiving or will receive in the above-mentioned dental office/health facility. No one will have access to this data except in those cases where the providing of such information is mandatory. The person granting this consent has the right to view his/her data as well as the right to correct such data.

_____

legible signature of Patient or legal representative

_____

signature of attending dentist – accepting declaration of Patient

Granting of consent for photographs or other medical records to be used for the purposes of academic publications

If consent is given, please put an "X" in the appropriate box, while in the place intended for signature write the date, the words “I hereby give my consent” as well as the legible signature of the Patient.

I hereby give my consent:

☐ for the attending dentist to use medical photographs, X-rays, descriptions of my case for academic studies and training purposes, lecture presentations, as well as academic publications on condition that the Patient cannot be identified from the photographs and descriptions.

_____

write the date, the words “I hereby give my consent” as well as the legible signature of the Patient

☐ Other additional arrangements/consent: _____

_____

_____

_____

_____

_____

_____

_____

_____

write the date, the words “I hereby give my consent” as well as the legible signature of the Patient

Information regarding Patient's conduct following implant treatment, augmentation and sinus lifting.

To ensure a more effective healing process following the procedure please observe the following suggestions:

- do not smoke tobacco or consume alcohol on the day of the operation or on the two days following the procedure
- do not engage in any physical exercise
- eat and drink only after the local anaesthesia has worn off
- only consume liquid and soft foods
- do not bite in the implant region
- take care of other teeth by strictly observing oral hygiene
- only rinse the area around the wound; during the post-operative period do not use a power toothbrush on teeth in the area around the wound; after eating briefly rinse mouth with cold water or with a mouthwash recommended by a physician
- do not touch the implant area with fingers or tongue
- in case of bleeding contact a dentist immediately
- swelling may occur in operating site, as well as in the cheek or chin, which will disappear after a few days; cold compresses can help moderate such symptoms

After the procedure implants are usually immediately restored with provisionals. Final securing of implants occurs only 16 to 28 weeks after the placement. With two-phase implants where the gum is sutured, this means when the implants do not protrude from the mucous membrane, they are usually protected with healing screws after 16 to 28 weeks have passed. The appropriate final prosthetic restoration only takes place later.

It is important that the implants are evenly loaded. If you notice the provisionals supported on implants (crown, temporary bridge) are mobile (owing to premature contact with your teeth) please arrange to see a physician immediately.

Regards,

_____

Attending dentist

I acknowledge receipt of the information.

_____

legible signature of Patient or legal representative

Stamp of health care unit

Information regarding those problems and issues connected with the implant procedure that have been explained to the patient

Dear Patient,

The examination has shown that the placement of one or more artificial tooth roots (implants) may restore or improve your ability to chew on food. Implant placement may also be considered for aesthetic reasons. Following osseointegration (integration with the bone) implants can help fix crowns, bridges or dentures.

Implants made of titanium can function for ten or more years. However, no guarantee can be given for such a long period of time. The type of implant expected to be best for you will be chosen after your jaw bones have been examined and the appropriate measurements taken.

After administering a local anaesthetic, and more rarely under general anaesthesia, the gum around the implant site will be opened up in order to expose the bone. Burs will be used to form the implant bed in which the implant will be placed. The implant can be placed directly on the site of the lost tooth. Finally, the gum will be closed with sutures.

Sometimes, implant placement turns out to be impossible during the operation itself. The procedure will then be interrupted and the wound closed with sutures.

In normal cases implant healing takes from 4 to 7 months. During this time, the implant cannot be loaded, nor is chewing possible in this area, so as to not jeopardise the healing process. Once the implant has healed, gingivoplasty above the implant may turn out to be necessary for implant-prosthetic purposes. If the occlusal and anatomic conditions are favourable and the proper protocol is observed, immediate implant placement can be performed with immediate loading.

No physician can guarantee the success of his/her treatment nor rule out risk. General dangers in operational procedures of this type, such as, for example, infections, occur only rarely. Thanks to advances in medicine we can prevent these dangers occurring before they appear. Swelling of the cheek or lips may occur temporarily after the operation. Post-operative pain is rare.

Sometimes it is necessary to open up the maxillary sinus, which is located close to the implant area. In most cases the implant is accepted by the body without any harmful consequences. Only very rarely does the nasal cavity or maxillary sinus cavity become inflamed and thus require treatment.

In rare cases the inferior alveolar nerve in the area of lower molars may become damaged. In very rare cases permanent sensory disturbances may affect the lower lip region (numbness). However, lip mobility is not impaired.

In individual cases, the implants are rejected. They become excessively mobile during healing and must be removed or the implant placement has to be repeated.

To reduce risk to the absolute minimum please answer the following questions:

1. Do you suffer from any illness/disease?

YES/NO

If YES, please specify: _____

_____

2. Do you suffer from any allergies (for example hay fever, allergy to specific foods (e.g. fruit, medicines, plasters and bandages, local anaesthetics, metals)?

YES/NO

If YES, please specify: _____

_____

3. How have you coped with anaesthetic injections when having teeth extracted or undergoing other dental procedures?

_____

4. Do you have an increased tendency to bleed even with small wounds or after the extraction of teeth?

YES/NO

If YES, please tell us whether the bleeding subsides on its own and after how much time and whether it requires medicine (which ones): _____

_____

5. Are you taking any medication permanently/often?

YES/NO

If YES, what kind and how often: _____

The Physician will enter details about the Patient's health on his/her medical record sheet.

On the day of the implant procedure and on the next two days:

- don't smoke
- don't drink alcohol
- don't do any physical exercise
- limit your speaking
- only consume liquid and soft foods
- after eating briefly rinse mouth with cold water or a mouthwash recommended by a physician
- don't touch the implantation site
- maintain oral hygiene.

Injections administered to achieve local anaesthesia may weaken your ability to react in traffic. Unless your physician recommends otherwise you should not drive mechanical vehicles or ride a bike for 2-6 hours after the injection. Do not engage in any recreational sport and avoid extreme weather conditions (don't ski or travel in the tropics) for the first 4 weeks following implant placement.

Please schedule a visit immediately if you experience any unusual feelings in the implantation site.

Oral hygiene has a decisive impact on the success of the treatment. Only if you are prepared to clean your teeth and the implantation site carefully and precisely after every meal can implant success be assured. Never neglect hygiene procedures in the future.

I hereby declare that the physician has explained to me the procedure based on the suggestions listed in the information presented above, and that I obtained answers to all problems that concerned me.

I have no further questions and I do not need additional time to consider my decision.

I hereby consent to the proposed procedure

signature of attending dentist	*legible signature of Patient*

Stamp of health care unit

_____

place, date

Contract to perform placement of dental implants;

concluded on _____ between: _____,

address: _____ **represented by** _____

joint owners, known hereafter as the SURGERY,

and

Name and surname _____

Residential address: _____

PESEL/ID _____

Tel. _____

e-mail _____

known hereafter as the PATIENT.

§ 1

The PATIENT commissions and the SURGERY accepts the performance of implantation of dental implants the scope of which is specified in the "Patient Consent" of _____ .

§ 2

Under the clarifications included in the "Patient Consent", the SURGERY does not guarantee the expected treatment result which depends on many factors, including: level of disease advancement, Patient's personal features, general health condition and, most of all, patient's response to the applied procedure and agents. The SURGERY's obligation concerns the due action with the aim to achieve the planned reconstruction of the masticatory organ with application of the procedure compliant with the current state of knowledge and compliant with the agreed scope.

§ 3

The SURGERY's remuneration is _____ , payable with transfer/in cash until the date _____

§ 4

The PATIENT undertakes to personally cover the total of agreed costs of the planned medical procedures and costs of the applied materials, according to the enclosed price list and other written arrangements, and to cover the additional costs specified in the following points.

§ 5

If during the surgical procedure there is a need to change the procedure concept, i.e. expand the procedure scope or apply additional agents (materials), the PATIENT undertakes to cover the costs of the medical procedures and materials connected with it, according to the enclosed price list.

§ 6

The PATIENT undertakes to pay for the additional (other than planned) medical procedures and cover the costs of additional materials, not later than within 14 days upon the procedure performance.

§ 7

If during the surgical procedure there is a need to change the procedure concept, i.e. narrow down the procedure scope, the SURGERY undertakes to return the costs of unperformed medical procedures and the costs connected with it, according to the enclosed price list.

§ 8

If the treatment can be in part or in full financed from the resources of other national or commercial health funds or from the damages or provisions of insurance companies or other entities or persons, the PATIENT undertakes to seek the costs of the applied medical procedure on his own, without transferring the claim pursuit on the SURGERY where the procedure is to be performed.

§ 9

In case of lack of payment for the performed procedures or costs incurred by the outpatient clinic/doctor in connection with the procedure on the agreed date, the PATIENT undertakes to cover the statutory interests for default without additional request.

§ 10

If it becomes necessary to remove the implants in the period of integration of the implants with the bone (4-7 months upon the procedure) or upon this period, the PATIENT undertakes to cover the costs of removal of the prosthetics and implants as well as potential, newly agreed, repeated treatment, according to the SURGERY's price list.

§ 11

To all matters that are not settled, the appropriate provisions of the Civil code shall apply.

§ 12

The Contract comes into force on the date of its execution.

§ 13

The PATIENT can terminate the contract at any time. However, then he is obliged to return to the SURGERY all expenses which the latter incurred for the purpose of due performance of the order, including payment of the remuneration part which corresponds to the actions so far taken by the SURGERY and, if the termination was without important reason, he shall also repair the damage.
The SURGERY can terminate the contract at any time, however, when the termination is without an important reason, he is responsible for the damage.

§ 14

The Contract was drafted in two counterparts, one for each of the Parties.

Signatures of the parties:

SURGERY

PATIENT:
legible signature