



Approved by: Medical Director of Dentistry  
 In force since: 01.08.2019  
 Version number: 1

Surgery stamp details

**PATIENT'S CONSENT TO PROSTHETIC TREATMENT**

Name and surname	Birth date /idx no.
Address	PESEL

I voluntarily consent to: ... ..

(Type of planned prosthetic filling)

hereinafter referred to as the "service".

I declare that I have received exhaustive and comprehensive information pertaining to the aim of the medical service, its course, possible complications which may be associated with the service and conduct after the service has been performed.

I declare that the information which I provided on my state of health in the Dental history interview is complete and accurate. I undertake to inform my doctor on any changes to my health. I acknowledge that the aforementioned data are confidential.

I consent for radiological and photographic documentation to be collected during treatments and after prosthetic fillings are applied.

I have been informed:

1. on the type of procedure aiming to apply prosthetic fillings, what the procedure entails and how it will be performed.
2. on the risk and possibility of complications associated with the treatment method which I accepted,
3. on the proceedings, other than those planned which might be reverted to if unforeseen circumstances occur during treatment. In such a situation I consent for the quote to be altered.
4. on the possibility of pain during or after treatment; such a state may be experienced by some patients, but will only be temporary.
5. on the need to observe oral hygiene and to report for periodic 6 month check-ups, which is a condition for successful treatment.
6. on the treatment costs..... which I accept.

I undertake to confirm that each stage of works concerning aesthetics i.e. choice of teeth colour and shape, type of prosthetic filling is in accordance with my expectations by signing the treatment report. If after this takes place





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I wish to make a change to the form of the filling, I undertaker to cover the associated costs.

I undertake to observe doctors' recommendations and in particular those pertaining to oral hygiene and to attend scheduled check-ups.

I declare that I understood the answers provided to all my questions pertaining to the treatment and the possible complications as well as alternative treatment methods (including on failure to undergo treatment) and have no further questions. I understand that as is the case for all medical and dental procedures, positive treatment outcome is not guaranteed.

.....  
 (Interviewer's legible signature and stamp)

.....  
 (Patient's legible signature)

.....  
 (For minors between 16 and 18 y. o. consent of a legal guardian)

