

seal of the health care facility

\_\_\_\_\_ place, date

## Patient's consent to insertion of dental implants

### Patient:

first name and last name: \_\_\_\_\_

residential address: \_\_\_\_\_

PESEL: \_\_\_\_\_

contact telephone number: \_\_\_\_\_

e-mail: \_\_\_\_\_

### Health Care Facility/Practice:

name of the facility: \_\_\_\_\_

address of the registered office: \_\_\_\_\_

NIP (tax ID): \_\_\_\_\_

telephone number: \_\_\_\_\_

e-mail: \_\_\_\_\_

### Details of the main doctor:

first name and last name: \_\_\_\_\_

### Type of consent:

(mark "X" as appropriate and provide a legible signature of authorized persons with the appropriate type of consent)

**Patient's own consent**

consent expressed by the Patient themselves or in their own name

\_\_\_\_\_ legible signature of the Patient

**Parallel consent**

Consent granted simultaneously by the Patient and the statutory representative or guardianship court if the Patient:

- is over 16 years old
- or
- is incapacitated, but is able to express an informed opinion on the provision of health services to them

\_\_\_\_\_  
\_\_\_\_\_

legible signatures of the Patient and the Guardian/Custodian

**Details of the Parent, Guardian/Custodian\* in the case of Substitute or Parallel Consent:**

first name and last name: \_\_\_\_\_

residential address: \_\_\_\_\_

PESEL: \_\_\_\_\_

contact telephone number: \_\_\_\_\_

e-mail: \_\_\_\_\_

relationship to the Patient: \_\_\_\_\_

**Note:** In the “Relationship to the Patient” section, please provide the basis for providing care and show and enter the numbers and names of the appropriate documents:

- in the case of the Patient’s Parent — identity documents of the Patient (child) and the Parent
- in the case of a Guardian/Custodian — identity documents of the Patient and the Guardian/Custodian and a judicial decision establishing guardianship/custody

**Statement of the Parent/Guardian/Custodian\*:**

I declare that my parental rights\* have not been terminated or limited with regard to the exercise of guardianship\* the right to exercise custody\* in relation to:

\_\_\_\_\_

enter the Patient’s first and last name

\_\_\_\_\_  
legible signature of the Parent/Guardian/Custodian\*

\*delete as appropriate

**Recommended scope of the procedure:**

Recommended implantation site (number of implants):

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Additional information about the scope of the procedure or extension of the procedure:

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**Planned scope of the procedure approved by the Patient:**

Expected implant type:

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Expected place of implantation:

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Additional arrangements:

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Additional arrangements – prosthetics:

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I have been informed about all circumstances and risks associated with refusing consent to the recommended treatment.

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legible signature of the Patient or their  
Legal Representative

Pursuant to Article 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 Article 16-18 of the Act of 6 November 2008 on patient rights and the patient ombudsman (Journal of Laws of 2009, No. 52, item 417 as amended) I consent to the insertion of dental implants in the above scope in this practice.

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legible signature of the Patient or their  
Legal Representative

I consent to the performance of the necessary medical tests before the procedure, i.e.:

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\_\_\_\_\_  
legible signature of the Patient or their  
Legal Representative

I declare that I have been informed about all circumstances and risks associated with refusing consent to the recommended treatment, including refusing the treatment.

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\_\_\_\_\_  
legible signature of the Patient or their  
Legal Representative

\_\_\_\_\_  
signature of the main doctor accepting  
the Patient's declaration

I consent to local anesthesia (infiltration, nerve block), and I consent to the doctor choosing the type and amount of anesthesia during treatment. I have been informed about the complications related to the administration of anesthesia, the risks as well as alternative methods. I do not know of any contraindications to anesthesia YES/NO  
Contraindications to anesthesia:

\_\_\_\_\_  
Local anesthesia may impair your ability to react in traffic. Unless your doctor advises otherwise, you should not drive or ride a bicycle for 2-6 hours after the anesthesia is administered. During the 2 weeks after the procedure, unless your doctor advises otherwise, please do not engage in competitive sports and avoid extreme climatic conditions (skiing, traveling to the tropics). Please make an appointment immediately if you experience any unusual sensations at the procedure site.

\_\_\_\_\_  
legible signature of the Patient or their  
Legal Representative

\_\_\_\_\_  
signature of the main doctor accepting  
the Patient's declaration

# Patient's Declaration

## I declare the following:

1. On \_\_\_\_\_, an informative conversation was held between the above-mentioned Patient (if necessary, with their legal representative) regarding the insertion of implants or bone substitute materials. Various implant systems were discussed in terms of suitability in a given individual case.
2. Using information materials, X-rays, and photographs of previously treated cases and possible treatment concepts, the scope and course of the planned treatment were comprehensively explained to me. Possible side effects and risks were also presented to me in an understandable form.
3. After discussing other conventional treatment methods in the form of prosthetic solutions and after considering all the information important to me, and being aware of possible complications, I decide to undergo the procedure.
  - a. I have been informed about the risks associated with other treatment methods and the consequences of refusing the treatment. I understand that, as with all general medical procedures, positive results from treatment are not guaranteed. Additionally, the procedure is performed to remove a specific problem and may not eliminate other underlying problems. I know that I can withdraw my consent to treatment.
4. Cases where complications led to the loss of the implant were explained to me. I acknowledge that neither the doctor nor the facility can guarantee the expected effect of the treatment, which depends on many factors, including the Patient's personal characteristics, the Patient's health condition, past illnesses and the Patient's behavior after the procedure. It was explained to me that the proposed treatment has been successfully practiced for many years, although this method does not guarantee indefinite survival of the implants. It is not possible to determine the potential healing capacity of bone and gum tissue using modern diagnostic methods. In a small percentage of cases, for various reasons, they may be gradually lost.
5. I declare that I have been instructed in an accessible and understandable manner about:
  - a. my health condition and diagnosis,
  - b. proposed and possible diagnostic and treatment methods,
  - c. foreseeable consequences of their use or omission,
  - d. treatment results and prognosis,
  - e. all circumstances related to planned medical services,
  - f. consequences and risks associated with refusing consent to a given treatment.
6. If I do not understand the information provided to me (the Patient) by the doctor or medical staff, I undertake to provide the main doctor with information about the above-mentioned lack of understanding in writing, to the attention of the facility manager.
7. I declare that I have the right to submit a written request to the doctor to seek the opinion of an appropriate specialist or to organize a case conference.
8. I have been informed about the need to carry out additional tests after the procedure, and the doctor has also recommended how to behave after the procedure. I declare that I have been provided with written instructions: "Information on behavior after implantation, augmentation, and sinus lifting".
9. I realize that my general health condition affects the results of implant treatment, and I assure that in my medical history, I have disclosed all known diseases and ailments as well as the medications I am currently taking. I declare that I have provided comprehensive and true information regarding my health condition. I undertake to notify the main doctor in writing about any changes in my health condition.

10. I know that the final result of treatment and its durability largely depend on the Patient's behavior in the post-surgical period and later, and in particular on:
  - a. not smoking cigarettes, which has a very negative impact on the healing processes, because smoking cigarettes is a relative contraindication for implant prosthetic treatment,
  - b. reporting for periodic check-ups, i.e., in the first month after treatment and then once every six months; this is an essential requirement in the treatment process,
  - c. strict adherence to recommendations regarding proper oral hygiene.
11. I undertake to follow medical recommendations, in particular regarding oral hygiene, and to attend check-ups on scheduled dates .
12. I have been informed that in the second stage of treatment after implantation, the prosthetic and post-procedure surgical part should be performed in the practice where the implantation was performed. Otherwise, the practice where the implantation was performed is not responsible for the further course of treatment.
13. I acknowledge that during surgery, there may be a need to change the concept of the procedure (expand or reduce the scope), and I consent to the necessary change in the concept of the procedure, and in the event of extending the procedure, I undertake to cover the related costs in accordance with the attached price list.
14. After considering all the information that is important to me and being aware of possible complications, I make an informed decision to undergo the procedure.
15. Cases where complications led to the loss of the implant were explained to me.
16. I acknowledge that neither the doctor nor the facility can guarantee the expected effect of the treatment, which depends on many factors, including my (patient's) personal characteristics, my (patient's) health condition, previous diseases, and my (patient's) behavior after the procedure.
17. I know that the final result of the treatment and its durability depends to a large extent on my (patient's) behavior in the post-procedure period and later, and in particular on not smoking cigarettes, which has a very negative impact on the healing processes, because smoking cigarettes is a relative contraindication for treatment. If we decide to perform implantation, regeneration, bone and/or soft tissue augmentation, we would like to inform you that such a procedure is associated with a greater risk of rejection of the implant or failure to incorporate the regenerative material or transplanted soft tissues in the case of smoking.
18. Reporting for periodic check-ups, i.e., in the first month after treatment and then once every six months is an essential requirement in the treatment process.
19. I undertake strict adherence to recommendations regarding proper oral hygiene.
20. I have been informed that the period of integration of the implants with the bone is 4-7 months. In case there is a need to remove them within that time, the conditions and costs of re-inserting the implant were discussed with me.
21. Implantation procedure with additional bone augmentation (regeneration). We would like to inform you that such a procedure is associated with a slightly higher risk of rejection of the implant or failure to incorporate the regenerative material. There is no diagnostic method to determine the potential healing capacity of bone tissue after bone regeneration.
22. The patient should be aware that some of the elements may wear out and require replacement (screws, acrylic or composite resin elements). The replacement of these elements with new ones is carried out according to the prices applicable on the date of replacement.
23. The costs of prosthetic reconstruction on implants that have been damaged due to mechanical reasons that is not the cause of normal use of the prosthetic reconstruction are borne by the patient in full in accordance with the prices applicable on the date of repair.
24. The facility does not cover the costs of repair/treatment in another practice in Poland or abroad.
25. The patient should be aware that in the case of missing teeth or loss of other teeth in the oral cavity, occlusal overload may occur, which may lead to the loss of implants, their breakage, or chipping of porcelain (from prosthetic reconstruction on the implant, breakage of connectors). Missing teeth should be immediately replaced (using implants, bridges, or dentures). If they are not replaced, we are not responsible for the implants and reconstruction of them.
26. I know that I will incur travel costs to perform the proposed, approved treatment, as well as check-ups and visits that will be dictated by medical reasons. These costs include the costs of travel by own means of transport, plane, train, etc., costs of accommodation in a hotel, guesthouse, etc., and all costs of the patient's stay with the persons accompanying them for the time that will be necessary for proper treatment. These costs are not included in the costs of treatment and, in no case, are charged to the doctor or the entity.

27. I consent to the provision of the above-mentioned medical services at the facility by the main doctor and any other doctor and medical staff (according to their qualifications). I acknowledge and accept that the term “doctors and medical staff” means all persons providing health services in this facility, regardless of the form of employment or cooperation.
28. I consent to the presence of interns or other doctors or staff for teaching purposes during health services provided to me (the Patient), provided that they stay there with the consent of the manager of the facility.
29. I declare that I have received access to information about Patient rights — on the information board.
30. I declare that I am aware of and accept the conditions for placing/leaving outerwear in the waiting room, which is a generally accessible place. I have acknowledged and accepted that doctors and staff of the facility deal with and are focused on providing health services; therefore, doctors or staff cannot take care of clothing or other items left in the waiting room. Therefore:
  - a. I undertake not to leave briefcases, bags, handbags, documents, cash, other valuables, payment cards, jewelry, vehicle or apartment keys, or other similar items in the waiting room without my supervision.
  - b. If I need protection against the loss of the above-mentioned items or outerwear when providing me (the Patient) with health services, I undertake to inform about the above to the doctor or staff and entrust them with the above-mentioned items to be stored in a room separate from the waiting room or in a closed closet.
  - c. I waive any claims against the facility in the event of loss of clothing or other items resulting from my failure to comply with the above provisions.

I declare that the above-mentioned declarations are fully understandable to me, and I submit them in accordance with the facts. I do not raise any objections or comments.

Aware of the benefits and possible complications, I consent to the procedure being performed in the above-mentioned scope.

Attached:

1. Information about behavior after implantation, augmentation, and sinus lifting
2. Information regarding a conversation explaining the issues related to implantation
3. Contract for the insertion of dental implants
4. Price list

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legible signature of the Patient or their  
Legal Representative

I consent to provide information about my health condition, diagnosis, proposed and possible diagnostic and treatment methods, predictable consequences of their use or omission, treatment results, and prognosis to other persons, i.e.:

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\_\_\_\_\_  
legible signature of the Patient or their  
Legal Representative

I declare that I have read the information regarding personal data protection

\_\_\_\_\_  
legible signature of the Patient or their  
Legal Representative

\_\_\_\_\_  
signature of the main doctor accepting  
the Patient's declaration

## **Consent to the use of photos or other medical documentation for scientific publication purposes**

If consent is given, put an "X" in the appropriate box and, in the space provided for the signature, enter: the date, "I consent" and affix the Patient's legible signature.

### **I consent to:**

the processing of my personal data included in this form by us, which we process in connection with providing you with medical services by our dentist \_\_\_\_\_ by using them for educational purposes during training for dentists, and for scientific publications in the scope specified below.

This consent will include the processing of personal data, without disclosing your first and last names, in the form of:

1. Age
2. Sex
3. Information about the diagnostic process,
4. Information about the course of the treatment process and the treatment methods used
5. X-rays
6. Photographs of the oral cavity before, during, and after treatment
7. Photographs of the face before, during, and after treatment
8. Additionally: \_\_\_\_\_

You may withdraw your consent in writing, and your data will no longer be processed for the purposes indicated in this form from the date of receipt of such declaration.



I \_\_\_\_\_ PESEL \_\_\_\_\_ consent to the use of my personal data in the above scope for educational purposes during training for dentists and for scientific publications,

\_\_\_\_\_  
“I consent” + date + legible signature of the Patient

Other additional arrangements/consents:

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\_\_\_\_\_  
“I consent” + date + legible signature of the Patient

The location for records of materials used, including implants:

## Information about behavior after implantation, augmentation, and sinus lifting

In order to promote the healing process after the procedure, please follow the following instructions:

- on the day of surgery and two days after the surgery, do not smoke or drink alcohol,
- do not undertake any physical exertion,
- eat and drink only after local anesthesia wears off,
- eat only liquid and soft food,
- don't bite around the implant,
- take care of the remaining teeth using strict oral hygiene,
- only rinse the mouth around the wound; after the procedure, do not use an electric toothbrush in the wound area. After eating, rinse your mouth briefly with cold water or the mouthwash recommended by a doctor,
- do not touch the implant area with your fingers or tongue,
- In case of any hemorrhage, contact your dentist immediately,
- there may be swelling around the surgical site, cheek, and chin, which will disappear after a few days; these symptoms can be alleviated by applying cold compresses.

After the procedure, the implants are most often immediately provisionally dressed. Final securing occurs only 16 to 28 weeks after the procedure. In the case of two-phase implants that are sutured, i.e., when the implant does not protrude from the mucosa, the implants will be secured with healing screws usually after 16 to 28 weeks. Only then does the actual prosthetic reconstruction take place.

It is important that the implants are loaded evenly. If you notice that the provisional implant securing (crown, temporary bridge) is moving (due to premature tooth contact), please immediately visit your dentist. I declare that the above information is understandable to me, and I have no questions in this regard.

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main doctor

I confirm receipt of the information.

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legible signature of the Patient or  
their Legal Representative



seal of the health care facility

## **Information regarding a conversation explaining the issues related to implantation**

### **Dear Patient,**

The examination showed that by implanting one or more artificial tooth roots (implants), your ability to chew food can be restored or improved. Insertion of implants may also be considered for aesthetic reasons. Inserted implants will be used to attach crowns, bridges, or dentures after osseointegration (fusion with the bone).

Implants made of titanium can function for ten or more years. However, it is not possible to provide such a guarantee. The most favorable type of implant for you will be selected after appropriate measurements and examinations of the jaws.

Using local anesthesia, or less often under general anesthesia, the gum in the implantation area is opened to expose the bone. Drills are used to create a bed in which the implant will be placed. The implant can be placed directly in the place of a lost tooth. Finally, the gum will be sutured.

Sometimes it turns out during surgery that implantation is not possible. The procedure is then interrupted, and the wound is closed with stitches.

Normally, it takes 4 to 7 months for the implant to heal. During this time, you cannot put any load on the implant or chew in this place so that the healing process is not jeopardized. After the implant has healed, it may be necessary to perform gingival plastic surgery over the implant in order to perform implant prosthetic work. If the anatomical and occlusal conditions are favorable and the appropriate procedure is followed, immediate implants can be inserted and loaded immediately.

No doctor can guarantee the success of the treatment or exclude risks. General risks associated with this type of surgery, such as infections, are rare. Thanks to progress in medicine, we can counteract this in advance.

After the procedure, temporary swelling of the cheek or lips may occur. Postoperative pain is rare.

Sometimes, it is necessary to open the cavity of the maxillary sinus, which is located near the implantation area. Most often, the implant is integrated without harmful consequences. Very rarely, inflammation of the nasal cavity or maxillary sinus occurs and requires treatment.

In rare cases, the inferior alveolar nerve may be damaged in the area of the mandibular molars. Very rarely, there may be permanent sensory disturbances in the lower lip (numbness). However, there is no impairment of lip mobility.

In individual cases, the implants do not integrate. They become excessively mobile during the healing period and must be removed, or the implantation is repeated.

**To minimize this risk as much as possible, please respond to the following questions:**

1. Are you ill?

YES

NO

If yes, please list your illnesses: \_\_\_\_\_

\_\_\_\_\_

2. Do you have any allergies (e.g., hay fever, allergy to certain foods, e.g., fruit, medicines, patches, local anesthetics, metals)?

YES

NO

If yes, please list your illnesses: \_\_\_\_\_

\_\_\_\_\_

3. How have you tolerated anesthetic injections during tooth extractions or other dental treatments so far?

\_\_\_\_\_

\_\_\_\_\_

4. Is there an increased tendency to bleed even with minor cuts or after tooth extraction?

YES

NO

If YES, please provide information on whether the bleeding stops itself, and after what time and whether it requires medication (which ones):

\_\_\_\_\_

\_\_\_\_\_

5. Do you take medications permanently/frequently?

If YES, what and how often:

\_\_\_\_\_

\_\_\_\_\_

**Detailed information about the health condition will be entered by the doctor into the Patient's record.**

On the day of the implantation procedure and during the next two days, please:

- do not smoke
- do not drink alcohol
- do not undertake any physical exertion
- limit speaking
- eat only liquid and soft food
- after eating, rinse your mouth briefly with cold water or a mouthwash recommended by your doctor
- do not touch the implant area
- maintain oral hygiene

Injections given for local anesthesia may impair your ability to react in traffic. Unless your doctor advises otherwise, you should not drive or ride a bicycle for 2-6 hours after the injection. During the 4 weeks after implantation, please do not engage in competitive sports and avoid extreme climatic conditions (skiing, traveling to the tropics).

Please make an appointment immediately if you experience any unusual sensations at the implantation site.

Oral hygiene has a decisive influence on the success of the treatment. Only if you are willing to thoroughly clean your teeth and the area around the implant after every meal can the success of the implant be assured. You should never abandon hygienic procedures in the future.

**I declare that the doctor conducted an explanatory interview with me today based on the instructions contained in the above information, during which I was able to get answers to all the questions I had.**

**I have no further questions and I do not need additional time to think.**

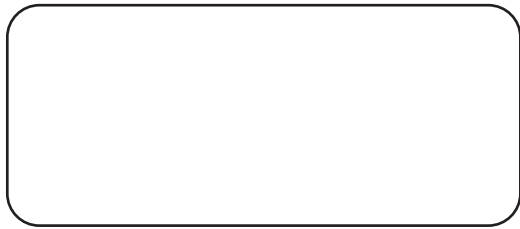
**I hereby consent to the proposed procedure.**

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signature of the main doctor

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legible signature of the Patient



seal of the health care facility

\_\_\_\_\_ place, date

## Contract for the insertion of dental implants

concluded in \_\_\_\_\_ by and between \_\_\_\_\_,  
address \_\_\_\_\_ represented by \_\_\_\_\_

owners, hereinafter referred to as the PRACTICE,

and

first name and last name: \_\_\_\_\_

residential address: \_\_\_\_\_

PESEL: \_\_\_\_\_

contact telephone number: \_\_\_\_\_

e-mail: \_\_\_\_\_

hereinafter referred to as the PATIENT.

### § 1

The PATIENT orders and the PRACTICE accepts the performance of the procedure of insertion of dental implants described with regard to the scope in the "Patient Consent" of \_\_\_\_\_.

### § 2

According to the explanations contained in the "Patient Consent", the PRACTICE does not guarantee the expected effect of the treatment, which depends on many factors, including: the stage of the disease, the Patient's personal characteristics, general health condition, and above all, the Patient's reaction to the procedure and measures used. The PRACTICE's obligation concerns diligent action in order to achieve the planned reconstruction of the masticatory system using a procedure consistent with the current state of knowledge and in accordance with the agreed scope.

### § 3

The PRACTICE's remuneration is \_\_\_\_\_ payable by transfer/cash by \_\_\_\_\_.

### § 4

The PATIENT undertakes to personally cover the entire agreed costs of planned medical procedures and the costs of materials used in accordance with the attached price list or other written arrangements, and to cover the additional costs described in the following points.

### § 5

If, during a surgical procedure, there is a need to change the concept of the procedure by extending the scope of the procedure or by using additional measures (materials), the PATIENT undertakes to cover the related costs of the medical procedures and materials used, in accordance with the attached price list.

## § 6

The PATIENT undertakes to pay for additional (over what is planned) medical procedures and to cover the costs of additional materials, maximum within 14 days of the procedure.

## § 7

If, during a surgical procedure, there is a need to change the concept of the procedure by reducing the scope of the procedure, the PRACTICE undertakes to reimburse the costs of unperformed medical procedures and related costs, in accordance with the attached price list.

## § 8

In the event that the treatment, in part or in whole, could be financed from other national or commercial health funds or from compensation or benefits provided by insurance companies or by other entities or persons, I undertake to recover the costs of the medical procedure used on my own, without assigning pursuing claims to the PRACTICE where the procedure is to be performed.

## § 9

In the event of failure to pay within the agreed deadline for procedures performed or costs incurred by the clinic/doctor in connection with the procedure, I undertake, without additional notice, to cover the statutory default interest.

## § 10

If it is necessary to remove the implants during the period of integration of the implants with the bone (4-7 months after the procedure) or after this period, the PATIENT undertakes to cover the costs of removing the prosthetics and implants as well as any newly agreed treatment in accordance with the PRACTICE'S price list.

## § 11

In unregulated matters, the relevant provisions of the Civil Code apply.

## § 12

The contract enters into force on the day of its signing.

## § 13

The PATIENT may terminate the contract at any time. However, they should reimburse the PRACTICE the expenses incurred in order to properly perform the order, including payment of part of the remuneration corresponding to its held until then activities, and if the termination takes place without a valid reason, they should also remedy the damage.

The PRACTICE may terminate the contract at any time, but if the termination occurs without a valid reason, it is liable for the damage.

## § 14

The contract was drawn up in two identical copies, one copy for each party.

signatures of the parties

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PRACTICE

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PATIENT  
legible signature