APPROVED BY
Order No. 52 of October 17, 2013 passed by Chief Physician of the
Public Institution Šiauliai Central Multi-Specialty Clinic

INFORMED CONSENT FOR SURGICAL INTERVENTION

I hereby give my consent to Dr. .....
to perform the following: .....

I confirm that I understand the following:

1. Additional procedures that may be required include local anesthesia, clinical or instrumental tests, x-ray scans, dental treatment, diagnostic, oral hygiene and/or other preventive procedures.
2. The following complications are possible after the surgery: pain, swelling, bleeding and spreading of infection to the surrounding tissues. In cases of extraction of maxillary teeth, the maxillary sinus can be injured. Other possible occurrences: bone erosion, fractures and/or breaking of teeth and roots, jaw fracture, tooth luxation (dislodgment), fractures, breaking, dental filling fracture, breaking or falling out, dental prosthesis getting loose, mandibular dislocation, allergic reactions, possible emotional reactions, such as fainting, spasming or collapsing.
3. Other possible complications: damage to oral and head organs, vascular or nerve damage, choking, foreign body intervention into the surrounding tissues, respiratory or gastrointestinal tract and the maxillary sinus. In case of vast spread of infection, a fever, sensation of feeling hot and cold, sepsis and anaphylactic shock may occur.
4. Dental implant failure to integrate with the bone, abutment fracture, fixing elements getting loose or fracturing.
5. Unpleasant sensations: oral and facial numbness, nausea, temporary speech, chewing or swallowing disorders, temporary seeing double, weakness, dizziness, taste and/or other sensory processing disorders.
6. The possibility of complications increases in case of poor oral hygiene, failure to follow the doctor's instructions, assigned regimen and recommendations, low immune system, diabetes mellitus, after radiotherapy or chemotherapy. Healing is also slowed down by smoking.
7. I have been duly informed that unforeseen circumstances may occur, leading to additional interventions. I hereby give my consent to the doctor to perform all necessary procedures relying on his/her professional competence.
8. I have been duly informed that in case I refuse to undergo the procedures, the expected results will not be achieved and my dental and/or oral diseases will progress, not to mention the infection may spread and I may have purulent complications and sepsis.

To my best knowledge, I am not allergic to any medications, except for (if applicable):
.....

I regularly take / do not take blood thinners (please underline the appropriate).

I had a heart attack or a stroke ……. months ago: yes / no (please underline the appropriate).

I hereby give my consent:

Signature……
First name and family name of the patient (if signed by an authorized representative, please indicate the legal basis of representation)
……
Date of birth: ……
Date……