Oral Surgery and Dental Extractions Informed Consent

Treatment: MYSHA MUMTAZ FILE 1925

I understand that oral surgery and/or dental extractions include inherent risks such as, but not limited to the following:

1. **Injury to the nerves**: This would include injuries causing numbness of the lips, the tongue, and any tissues of the mouth and/or cheeks or face. The numbness which could occur may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. **Bleeding, bruising, and swelling**. Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.

3. **Dry Socket:** This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful if not treated. These usually develop 3-4 days after the surgery.

4. **Sinus involvement**. In some cases, the root tips of upper teeth lie in close proximity to sinuses. Occasionally during extraction or surgical procedures the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically closed. Root tips may need to be retrieved from the Sinus.

5. **Infection**. No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur post-operatively. These may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.

6. **Fractured jaw, roots, bone fragments, or instruments**: Although extreme care will be used, the jaw, teeth toots, bone spicules, or instruments used in the extraction procedure may fracture or be fractured requiring retrieval and possibly referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery, which could cause more harm and add to the risk of complications.

7. **Injury to adjacent teeth or fillings:** This could occur at times no matter how carefully surgical and/or extraction procedures are performed.

8. **Bacterial Endocarditis**: Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems known or suspected or of any artificial joints I may have.

9. **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

10. It is my responsibility to seek attention should any undue circumstances occur post-operatively and I shall diligently follow any pre-operative and post-operative instructions given to me.

Informed Consent

As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fees for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. John A. Hodges and his associates to render any treatments necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Name of Patient MYSHA MUNTAZ FILE 1935

Signature of Patient & Date [signature] 29/4/2023

Signature of Doctor & Date _____

Informed Consent for Scaling and Polishing

Diagnosis

After careful examination, the Doctor informed me that I have gingival/periodontal disease in all or some areas of my mouth. I understand that periodontal disease weakens the support of my teeth by separating the gum from the teeth and destroying some of the bone that supports the tooth roots. I have been made aware of the fact that if left untreated, periodontal disease can cause me to lose my teeth and I can have other adverse consequences to my general health.

Recommended Treatment

In order to treat my periodontal condition, the Doctor has recommended that my treatment include scaling/ root planning with a local anesthetic. The purpose of this therapy is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my condition may require additional treatment that may include a second deep cleaning, periodontal surgery, or antibiotics.

Treatment Risks

Risks may include, but are not limited to:

- Swelling, pain, and bleeding after treatment
- Gum recession and root exposure
- Sensitivity to hot, cold, and sweets
- Infection
- Increased spacing and food impaction between teeth.
- Initial looseness of teeth. Most will tighten up, but not all will
- Numbness in the tissues

No Warranty and Self Responsibility

There is no method currently available that will predict how the gum and bone will heal following any periodontal procedure. Because each patient's condition is unique, long-term success may not occur. In addition, the success of treatment can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, medications, and inadequate oral hygiene. I understand that after the proposed treatment has been completed, constant monitoring of my condition will be necessary. This will mainly consist of regular 3-month recall visits to the office. I understand that my personal oral hygiene is the key to the prevention and successful treatment. If satisfactory plaque control is not maintained, recurrence of periodontal disease is likely.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE CONSENT AND AGREE TO START TREATMENT AS PROPOSED BY THE DOCTOR.

Patient: MYSHA MUNTAZ FILE 1935 Date: 29/4/2023

Witness: _____ Date: _____

Dentist: _____ Date: _____

Informed Consent for Tooth Fillings

File No	:	1935	Date	:	29/4/2023
Patient Name	:	MYSHA MUNTAZ FILE 1935	Gender	:	Female
Nationality	:	BRITISH	DOB	:	4/02/2013
Emirates ID No.	:	784-1993-7529816-5			

UNDERSTAND that the treatment of my dentition involving the placement of composite resin fillings which may be more aesthetic in ppearance than some of the conventional materials [which have been traditionally used to fill front and back teeth], such as silver malgam or gold, may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I gree to assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this reatment.

ENEFITS:
liminate decay, relieve pain, fill in a hole or space in a tooth, cover eroded area, and protect a sensitive surface

ONSEQUENCES OF NOT HAVING WORK DONE or POSTPONING :
Aay loose the tooth, tooth may fracture, decay will get worse, may result in need for a root canal

LTERNATIVES:
emporary filling

OSSIBLE COMPLICATIONS:
ooth may abscess from the filing, may fracture the tooth, tooth can be sensitive to temperature change, or filling may fall out.

lecessity for Root Canal Therapy:
When any type of fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure adequate to insure sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue.
Should the pulp not heal, which oftentimes is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

njury to the Nerves:
There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which could occur is usually temporary, but in rare instances could be permanent.

Aesthetics or Appearance:
Effort will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, smoking, etc. may exhibit a change in shade. The dentist has no control over these factors. Tooth lightening may also result in fillings in front teeth becoming relatively darker.

Breakage, dislodgment or bond failure:
Due to extreme chewing pressures or other traumatic forces, it is possible for composite resin fillings or esthetic restorations bonded with composite resins to be dislodged or fractured. The resin enamel bond may fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

Patient's Initials:

I understand that ALL medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of dentistry, provided my identity is not revealed

It is the patient's responsibility to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions, including the scheduling and attending all appointments. In the event I wish to discontinue the treatment, I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall health may be affected by my decision.
I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in My overall health stemming from this condition.
I have had the chance to ask questions and express concerns about my dental condition, the treatment options, and my refusal of treatment. The undersigned provider has answered all my questions and addressed all my concerns. I understand the full scope of the situation and am making an informed decision.

nformed Consent:

he fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my onsent to allow and authorize Dr. and / or his associates to render treatment and administering or any medicationsand / or anesthetics eemed necessary for my treatment.

- [x] I have been given the opportunity to ask questions and give my consent for the proposed treatment as Described above.
- [ ] I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

<u>Sign here, only if all of your questions have been answered to your satisfaction</u>

MYSHA MUMTAZ — 29/4/2023

Patient's name | **Signature of Patient Legally authorized Representative** | **Date**

Witness Signature | **Date**

Dentist's Signature | **Date**