PATIENT CONSENT FOR DENTAL SURGERY

Patient Name	:	Syed Shahid Ali Shah	**File No**	:	2690
Nationality	:	Pakistani	**Gender**	:	Male
Emirates ID No.	:	999-9999-9999999-9	**DOB**	:	27-01-1984

1. I, the undersigned, hereby consent to Dr. Shyam Bhat performing the following procedure(s):

2. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment.

3. I have been advised of possible complications of this procedure that are able to be reasonably anticipated, which are:

- Injury to a nerve, resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue to the operated side. This may persist for several weeks, months, or, in remote instances, permanently.
- Postoperative infection requiring additional treatment.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Restricted mouth opening for several days or weeks, with possible dislocation of the Temporomandibular (jaw) joint.
- Injury to adjacent teeth and fillings.
- In rare circumstances, breakage of the jaw.
- Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
- Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
- Stretching of the corners of the mouth with resultant cracking and bruising.

Wisdom Teeth Extractions (in addition to the above):

Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. Upon my consent, I will authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medication s until I am fully recovered from their effects. I have also been advised not to smoke for two weeks after the surgery. By signing below, I give my permission for the anesthetic and oral surgical procedures agreed upon by myself and Dr. Shyam Bhat. The proposed surgery and risks have been fully explained to my satisfaction and I have had the opportunity to ask questions. I also verify that to my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health

4. I acknowledge receiving a copy of the post-operative instructions, which have been explained to me. I understand all the advice given to me by my Dental Surgeon. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

5. I understand that no guarantee can be given of the results of surgery on the human body, but that the doctor and office staff will do their best to achieve excellent results.

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

7. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

BP: 136/80

Patient's Initials:

8. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. You have the right to refuse or discontinue treatment. You will be informed about the consequence of your decision to refuse or discontinue treatment and about available care and the treatment alternatives.

Sign here, only if all of your questions have been answered to your satisfaction

Patient / Parent / Guardian Signature: **If Guardian, relation to the Patient**

Soniya

Witness Name **Witness Signature** **Witness ID**

Dr. Shyam Bhat 12-12-2023

Dental Surgeon's Name **Dental Surgeon's Signature** **Date**

Dr. Shyam Bhat
Specialist Oral & Maxillofacial Surgery
DENTISTREE DHA-00212475-005
DENTISTREE DENTAL CLINIC