PATIENT CONSENT FOR DENTAL IMPLANTS

Patient Name	:	NAINA KUMAR BATHEJA	**File No**	:	215
Nationality	:	Indian	**Gender**	:	Female
Emirates ID No.	:	784-1948-8469531-6	**DOB**	:	24-Apr-1948

This form will acknowledge your consent to treatment recommended by your Dental Implantologist

1. I authorize Dr. Akshaya Kulkarni to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

I authorize placement of implants in the areas of teeth

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications which have been explained to me.
3. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications include the very rare potential of risks or complications, such as damage to vital organs including the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.
4. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following: • Postoperative pain, discomfort and swelling • Bleeding • Postoperative infection • Injury or damage to adjacent teeth or roots of the teeth • Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling or pain of the chin, lips, cheek, gums or tongue • Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw — temporomandibular joint (TMJ) syndrome • Fracture of the jaw • Bone loss of the jaw • Penetration into the sinus cavity • Mechanical failure of the anchors, posts, or attached teeth • Failure to implant itself • Allergic or adverse reaction to any medications.

Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

Patient's Initials: NB

5. 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.
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.
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.

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.

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.

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

Patient / Parent / Guardian Signature: Nainaw Bathija

If Guardian, relation to the Patient

Witness Name Reena

Witness Signature

Witness ID

Dr. Akshaya Kulkarni

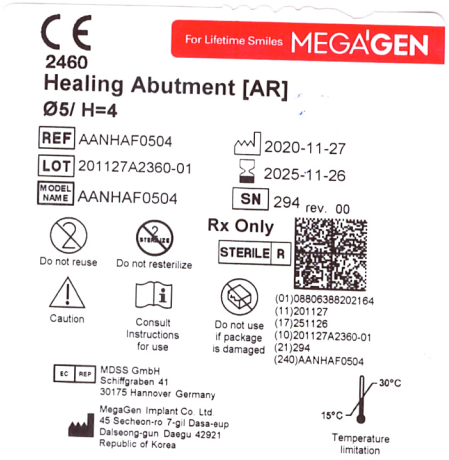
04-Oct-2021

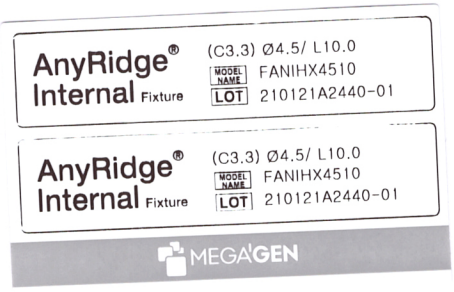
Doctor Name

Doctor Signature

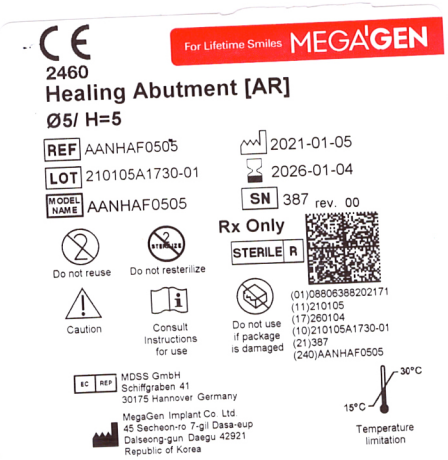
Date

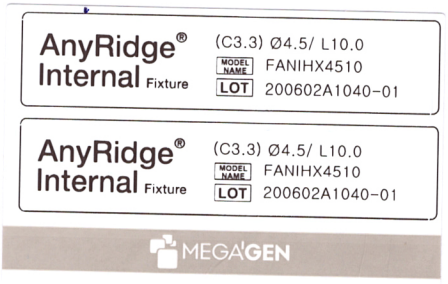
BP - 120/90
PR - 67





35





36