MEDSTOM Dental Clinics

Sofia, 6 Stefan Stambolov Blvd and 26A, Knyaz Al. Dondukov Blvd, www.medstom.bg

DECLARATION for Informed Consent for the performance of clinical oral hygiene

Date: Name:

1. I grant my permission, and thus my consent, to be treated by Dr. .....due to the presence of the following diseases/conditions: .....

.....

2. The procedures/procedure necessary for the treatment of my illness/ illnesses have been explained and I understand what the following manipulations are: tartar cleansing, therapeutic curettage (gut cleaning) and topical fluoride administration; ....

3. I have been informed of other possible treatments (if any) that are: .... I understand that these medical treatments are my personal choices and the risks from them have been explained to me. I understand that I can choose these treatment events as other variants of my treatment and the risks from them have been explained to me.

4. I agree with the application of local anesthesia in connection with the abovementioned procedures.

5. The subsequent complications of the dental hygiene procedures (dental prophylaxis - dental cleansing, therapeutic cleansing and local fluoride application) include (but are not limited to) the following symptoms:

□ bleeding, discomfort, infection

□ increased sensitivity due to the removal of tooth deposits and root surface smoothing (under the gum)

□ soft-tissue reaction to fluorinated application, which includes: redness of the tissues, nausea / vomiting if the preparation is swallowed and temporary peeling / peeling of the mucosal tissues

□ falling loose or broken obturations, inserts (seals) or crowns

□ Complications associated with local anesthesia (although rare) may include: pain, swelling, bruising, infection, nerve damage and unexpected allergic reactions that may lead to heart attack, stroke, brain damage and / or death

6. I understand that during the treatment the hygienist may discover other unforeseen pathological conditions that may require different procedures than the ones originally planned. I authorize them to perform such other procedures as they consider necessary, according to their professional judgment. I understand that no guaranteed results are promised to me and I give my free and voluntary consent to treatment.

I certify that I have read or have been given complete / detailed explanations and I fully understand the terms contained in the text above and voluntarily give my consent to the planned / surgical intervention.

....

signature of the patient/legal guardian signature of a witness