TRUMAN MEDICAL CENTERS

☐ Hospital Hill ☐ Lakewood

Patient Identification

SPECIAL CONSENT TO OPERATION/PROCEDURE - DENTAL

Date: ______________________ Time: ______________________

Section I: I ______________________ (or ______________________ for ______________________), hereby authorize Dr. ______________________ and/or such associates or assistants as may be selected by him to perform the following procedure(s) ______________________ to treat or diagnose the following condition or conditions **(explain the nature of the condition and the need to treat such condition):** Dental Caries / Malerpution / Gum Disease (Periodontitis)

Alternatives to this procedure are: ______________________ s ______________________

Section II: The procedure(s) necessary to treat or diagnose my condition has (have) been explained to me by Dr. ______________ and I understand the nature of the procedure(s) to be **(a description of the procedure(s) in lay terms):** Numbing area with local anesthetic, extracting the above-mentioned teeth (this may involve making an incision in the gum and removing bone around the badly broken down or impacted teeth and stitching the gums).

Section III: I have been made aware of certain risks and consequences that are associated with the procedure(s) described above. These are **(a description of the risks and consequences that are involved in this particular procedure):** Bleeding, infection, damage to adjacent teeth, dry socket, jaw fracture; Upper teeth: sinus involvement; Lower teeth: nerve damage; Abnormal or untoward reaction to medications or conditions requiring additional surgery.

I have also been informed there are other risks such as loss of blood, infection, cardiac arrest, etc. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I hereby authorize Truman Medical Centers, Inc. to preserve for scientific or teaching purposes, or for use in grafts upon living persons, or otherwise dispose of the dismembered tissue, parts or organs resulting from the procedure(s) authorized above.

I hereby authorize the release of my name and other required information to the manufacturer of the medical device that I am to receive, in accordance with Federal Food and Cosmetic Act. I further understand that my name and other information may be used by the manufacturer to locate me, if there is a need to contact me in regard to this medical device.

I have been informed that Truman Medical Centers, Inc. are academic, teaching hospitals. I consent to the presence of medical, dental, nursing and other students whose presence is deemed appropriate by the attending physician, for the purpose of advancing the educational mission of the Hospital.

I have been informed that health care industry representatives may be permitted access to the operating room at Truman Medical Centers, Inc. for the purpose of providing technical support during a surgical intervention.

I hereby consent to the taking of pictures, television recordings or videotape recordings of medical or surgical conditions or procedures, and use of such pictures or films for educational purposes, without expense to me.

I consent to the above radiologic procedure. I understand that if I am pregnant, there could be additional risks, including potential adverse effects to me and/or my embryo or fetus.

In the event that a health care worker is exposed to my blood or other bodily fluid capable of transferring pathogens, I consent to the drawing of my blood or other fluid for testing for HIV, hepatitis or other blood-borne pathogens. I understand that tests for HIV are not 100% accurate and sometimes produce both false positive and false negative results. I understand that positive test results must be reported to the Missouri Department of Health, and that confirmed HIV antibody test results may also be made available, in summary or statistical form, that do not include patient identification.

I certify that I have read the above or have had it read to me, that it has been fully explained to me, and that I understand its contents. I have had an opportunity to ask questions, and all questions have been answered to my satisfaction.

______________________ Signature of Patient or Authorized Representative

______________________ Witness

______________________ Printed Name of Authorized Representative

______________________ Relationship to Patient

______________________ Physician or Member of Medical Staff Signature obtaining Consent

______________________ Interpreter Signature