CHRISTIANA CARE

CNSNT

Date of procedure: ___/___/___

Patient Name: _____

Patient DOB: ___/___/___

MRN: _____

CONSENT FOR PROCEDURE

I, _____, request and give consent to **Dr. Andrew Swiatowicz** to perform the following procedure(s)Comprehensive dental examination and radiographs for the creation of a treatment plan including, but not limited to: dental prophylaxis (cleaning), scaling & root planning, dental restorations (fillings) in amalgam or composite resin, extractions, root canals, crown preparations, impressions, and additional procedures as needed. Treatment plan to be fully completed at appointment. Additional procedures not already listed will be discussed with caregiver/legal guardian prior to starting said procedure.

The benefits, risks, complications, and alternatives to the above procedure(s) have been explained to me.

I understand that the procedure(s) will be performed at Christiana Care by and under the supervision of my doctor or provider. My doctor or provider may use the services of other doctors or providers or members of the resident staff as he or she deems necessary or advisable.

I authorize my doctor or provider and his or her associates and assistants to perform such additional procedures, which in their judgement are necessary and appropriate to carry out my diagnosis or treatment.

I authorize the hospital to retain, photograph, preserve and use for scientific, teaching purposes, or to make other dispositions of, at their convenience, any specimens, tissues, or parts taken, from my body during the course of this operation.

I consent to observers in the procedure area in accordance with hospital policy. I consent to a healthcare industry representative being present during the procedure, if necessary, to provide technical assistance or to perform calibration of equipment. I consent to photography or video taping of my surgical procedure for educational purposes, provided my identity remains anonymous and confidential.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me.

If anesthesia is required, I consent to the administration of anesthesia by members of the Department of Anesthesiology. I also consent to the use or non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in additional to those resulting from the operation itself, but not limited to dental injury, hoarseness, vocal cord injury, infections, nerve injury, corneal abrasion, seizures, heart attack, stroke and even death.
If applicable, I consent to the use of fluoroscopy. I understand that prolonged exposure to fluoroscopy man result in skin reactions, such as redness, irritation or a burn.

Please initial one of the following statements (females 55 years and under):

_____ To the best of my knowledge I am not pregnant. _____ I believe I am pregnant.

I certify that I have read the above consent statements, or they were read to me, and I understand them. In additional, I have been offered the opportunity to ask my doctor or provider any questions I have regarding the procedure(s) to be performs. My questions have been answered to my satisfaction. I acknowledge that I have been no guarantee or assurance as to the results that may be obtained from the procedure(s).

_____	_____	___/___/___	_____
Signature of Patient or Decision Maker	Relationship to Patient	Date	Time
_____	**801152569**	___/___/___	_____
Doctor or Provider Signature	Doctor or Provider Print Name or ID#	Date	Time
_____		___/___/___	_____
Witness Signature		Date	Time

Telephone Consent:

_____	_____		
Name of person providing consent	Relationship to Patient if Decision Maker		
_____		___/___/___	_____
Witness Signature		Date	Time
_____		___/___/___	_____
Witness Signature		Date	Time

Interpretation: The information has been presented to the: ☐ patient ☐ representative ☐ decision maker in (language); _____. The person who provided the interpretation is a qualified medical interpreter.

_____	_____		
Interpreter Name	Agency and ID# (if applicable)		
_____	_____	___/___/___	_____
Witness Signature	Print Name	Date	Time