Consent form for Facial Bone Surgery, Tumor Removal ,and Cyst Enucleation

Dental Hospital

Patient Information

Name..... Age ..... years HN .....

Diagnosis .....Treatment Method .....

Date..... Time..... Attending Dentist .....

1. **Procedure and Environment**

The attending dentists has explained that I required treatment, which may result in post-operative pain and swelling. Pain relief medication may be nevessary, and some bleeding is expected. Generally, bleeding can be controlled by applying gauze pressure.

2. **Major Risks of the Procedure**

Potential complications may include abnormal bleeding, severe pain, abnormal numbness, swelling, or infection. In some cases, the presence of pus may necessitate additional treatment or further surgical intervention.

Patient Acknowledgement

I have received the following information.

1. The attending dentist/ physician has explained my medical condition and the purpose of the procedure.
2. The risk, potential outcomes, and alternative treatment options have been discussed.
3. The prognosis, as well as the risks of not undergoing the procedure, have been clarified.
4. Information regarding anesthesia has been provided.
5. I have been given the opportunity to ask questions regarding my condition, the procedure, associated risks, and alternetive treatment. All my questions have been satisfactorily answered.
6. I understand that this procedure may involved blood transfusion if necessary.
7. The attending dentist/ physician has informed me that in case of na emergency during the procedure, immediate medical intervantion will be provided.
8. I acknowledge that no guarantees can be made regarding the improvement of my condition and that, in some cases, the condition may worsen.

Based on the above information, I confirm that I have received sufficient details and voluntarily consent to the proposed treatment.

Signature: .....
(.....)
Treating Dentist

Signature: .....
(.....)
Patient / Authorized Representative
Relationship to the patient: .....

Signature: .....
(.....)
Witness

Signature: .....
(.....)
Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.