



CNSNT

Date of procedure: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name:

DOB:

CONSENT FOR PROCEDURE

Side 1 of 2

I, \_\_\_\_\_, request and give consent to **Dr. Andrew Swiatowicz**

to perform the following procedure(s) **Comprehensive Exam, Prophy, Scaling and Root Planing, Amalgam/Resin Fillings, Extractions, Root Canals, Crown Preparations, Impressions, Radiographs, As Needed**

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 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 judgment 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 of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the operation itself including, but not limited to, dental injury, hoarseness, vocal cord injury, infection, 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 may 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 addition, I have been offered the opportunity to ask my doctor or provider any questions I have regarding the procedure(s) to be performed. My questions have been answered to my satisfaction. I acknowledge that I have been given 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: \_\_\_\_\_
Doctor or Provider Signature: *Dr. Andrew Swiatowicz* Doctor or Provider Print Name or ID#: **801152569** 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: \_\_\_\_\_