Jaws Family Dentistry
Dr Yaw Ahyia-Osae
Contact: 061 526-5146
20 Greenwood Str
Berea, East London
5241

Practice no: 1261045
Email: info@jawsdentistry.co.za

Patient Name:
DOB:

Informed Consent for Scaling and Root Planing

Confirm and agree that:

1. The dental practitioner on examination will be discussing/explaining a treatment plan, the risk and alternative treatment available to me.
2. I understand that if any changes occur in the treatment, it will be explained to me together with estimated costs.
3. I hereby give consent to the dental practitioner to perform Scaling and Root Planing procedure(s) ("Recommended Treatment") on me or my dependant and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment.
4. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.
5. Risks and Complications
   I understand that unforeseen complications may arise during treatment and may require different or additional treatment than what was explained to me. I give permission to the dental practitioner or any other specialist I am referred to, to carry out such further or different treatment as may be necessary in the dental practitioner or specialists' professional judgement.
6. I further understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These potential risks and complications include, but are not limited to, the following:
   - Drug reactions and side effects.
   - Post-treatment bleeding, oozing, and infection.
   - Bruising and/or swelling, delayed healing, restricted mouth opening for several days or weeks.
   - Varying lengths and degrees of sensitivity.
   - Increased spacing between teeth due to removal of hard deposits.
   - Revealing of recessed gums.
   - Increased mobility of teeth.

   Note: As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.
7. I understand that I can ask any question that I may have regarding treatment and fees charged before treatment begins.
8. I agree that my co-operation is important and shall keep scheduled appointments made for me and agree that I may be charged for appointments not kept.

9. I have been informed that the fees charged by this practice are for the most part based on the patient's individual medical scheme rates. However, there are certain procedures which might not be listed in my medical scheme, or where my scheme or insurance plan does not cover, Joyful Jaws rates (which may be above scheme rates for certain procedures or benefits) shall be applied. In these instances, the fees are determined by the dentist based on the quality of services, practice costs, quality materials and best practice rendered by Joyful Jaws.

10. I understand that I need to settle these fees on preparation of treatment. Furthermore, I understand that Joyful Jaws does not run accounts and that any amount due becomes payable immediately.

11. I authorize the dental practitioner to disclose to my medical scheme, funders, employers, or the following (Specialists, GPs, Pharmacists, Emergency Services) as directed by Joyful Jawsl, any dental records and information including any treatment plans, prescriptions and other information pertaining to my care by this practice. I understand that the reports may contain personal and confidential information which will be in strict accordance with HPCSA (Health Professions Council of South Africa) rules and POPIA (Protection of Personal Information Act).

12. I certify that I fully understand this consent.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Evidence:

- ☐ X-ray
- ☐ Pictures

Signature: _____ Date: _____

Dental Practitioner