INFORMED CONSENT OF THE PATIENT

GREEN DENTAL has the legal obligation to request and process this information according with decision nr.15/2016 below mentioned

This informed patient consent for dental treatments and investigations is conducted in accordance with **decision nr. 15/2016 on informed patient consent publicized in the official monitor, part I, nr. 1040, 23.12.2016, based on the art. 534, on the Law nr. 95/2006** on health reform, republished, with subsequent modifications and additions, from art. 660, the same law.

1. Patient personal information

1.1. First Name:_____ Last Name:_____

1.2. Adress: _____

2. The legal representative of the patient*

*Used in case of minors or adults with no discernment

2.1. First Name:_____ Last Name:_____

2.2. Adress: _____

2.3. Quality: _____

3. Treatment (description) _____

4. The following information was provided to the patient about the medical act:

4.1. Information about health status: ○Yes ○No

4.2. Diagnosis: ○Yes ○No

4.3. Prognosis: ○Yes ○No

4.4. The nature and purpose of the proposed medical act: ○Yes ○No

4.5. Interventions and the proposed therapeutically treatment: ○Yes ○No

4.6. The benefits and the consequences of treatment, focused on: ○Yes ○No

_____

4.7. The potential risks of treatment, focused on: ○Yes ○No

_____

4.8. Viable alternatives to the treatment and their risks, focused on: ○Yes ○No

_____

4.9. The risks in case of patient refusal: ○Yes ○No

4.10. The risks if you ignore the doctor's recommendations: ○Yes ○No

5. Consent for blood collection of other biological materials

5.1. The patient is agreeing with the collection, keeping and usage biological products: ○Yes ○No

6. Other information provided to the patient

6.1. Information about available medical services: ○Yes ○No

6.2. Information about the identity and professional status of the medical team*: ○Yes ○No

*Identified in the table with the medical personnel in charge with the patient's treatment

6.3. Information about the rules / practices in the medical unit, which must be followed: ○Yes ○No

6.4. The patient was been informed on his rights to a second medical opinion: ○Yes ○No

7. The patient wishes to be further informed about his health ○Yes ○No

I) IN CASE OF TREATMENT ACCEPTANCE

I) I, the undersigned, _____* declare that I understand all the information provided by Dr. _____**, that I have informed the doctor with true, valid information about my medical history and that I express my informed consent for this medical act.

* Patient Name/Legal representative
** First and last name of the dentist that informed the patient

_____ Date: _____ / _____ / _____

(Patient signature/Legal representative that consents for the medical act) Hour: _____ / _____

II) IN CASE OF TREATMENT REFUSAL

I) _____* declare that I understand all the information provided to me explicitly by Dr. _____**, that the consequences of the refusal of the treatment have been very clear explained to me by the doctor and that I express my refusal to further exercise the medical act.

* Patient Name/Legal representative
** First and last name of the dentist that informed the patient

_____ Date: _____ / _____ / _____

(Patient signature/Legal representative that refuses the medical act) Hour: _____ / _____