



Oral Surgery Consent Form

Patient

I consent to surgical procedure

Be performed by dr. _____ at White Clinic
Belgrade.

- I consent to photography and recording for the purpose of medical documentation. I agree that the photo-documentation may be used for medical-scientific, professional, or educational purposes, provided that the patient's identity is not disclosed to the public.
- The physician has explained the proposed therapeutic procedure and the expected results of the intervention.
- It has been explained to me, and I understand, that there are objective circumstances that may compromise the success of the therapy. I have been informed of possible side effects and complications that may occur during and after the intervention—such as postoperative swelling, hematoma, local bleeding, infection, restricted mouth opening (trismus), sensory disturbances (numbness), injury to the sinus cavity or adjacent teeth, etc.; I agree to the procedures necessary to resolve any such complications.
- I commit to adhering to the prescribed medication therapy, as well as the instructions and measures provided to me in writing and explained verbally.
- I have informed the physician about my health status and any therapy/medication I am currently taking.

Patient signature / Legal guardian signature

Date
