NATURAL SMILES

General and Implant Dentistry

Informed Consent for Phlebotomy and Plasma Rich in Growth Factors Development

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

REQUEST AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Patient's Name:

Date:

The following has been explained to me in general terms and I understand that:

(1) The purpose of the procedure is to enhance post-operative healing.

(2) The likelihood of success of the above procedure is:
( ) Good ( ) fair ( ) poor

(3) Practical alternatives to this procedure are not doing PRGF

(4) The nature of the procedure:

PRGF is a component of the patient's blood that contains growth factors. In order to process PRGF there will be a 36-72ml blood-draw using an aseptic technique. The blood will be processed, activated and added to the surgical procedure. To activate PRGF, the blood is mixed with calcium chloride.

I understand that PRGF is processed from my own blood and is therefore safe from disease transmission.

I understand that the medical/dental personnel and others will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been explained.

I understand that the practice of dentistry and medicine are not exact sciences and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described, it may be necessary or appropriate to perform additional procedures which may not be known to be needed at the time this consent is given. I authorize the persons described herein to make decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as may be deemed necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and other treatment or courses of treatment relating to the diagnoses or procedures described herein.

I also consent that any tissues or specimens removed from my body in the course of any procedures may be tested for scientific purposes and then disposed of within the discretion of the physician, facility, or other health care provider.

I understand that certain medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which may be increased by the use of alcohol or other drugs. Thus I have been advised not to drive or operate hazardous equipment or work while taking medications and/or drugs until I have fully recovered from the effects. I understand and agree that if I have been sedated or given general anesthesia, I will not operate any vehicle or hazardous device for 24 hours after my release from surgery. I agree not to drive myself home after surgery and will have a responsible adult drive me home after being discharged from surgery.

I understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible dentist/surgeon, all medical-dental personnel under direct supervision and control of the responsible dentist/surgeon and for any medical/dental personnel otherwise involved in the course of treatment.

I consent to photographs, recordings, and x-rays of the procedure to be performed for the advancement of dentistry.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND IT'S CONSENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK

QUESTIONS AND THAT ALL QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKKS OR STATEMENTS I DO NOT APPROVE OF WEERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN. I HAVE HAD THE OPPORTUNITY TO EVALUATE THE CREDENTIALS AND EDUCATIONAL BACKGROUND OF TREATING DOCTORS.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Edward Mills, involved in the course of my treatment.

Person giving consent (patient or legal guardian)

Relationship to patient if not the patient:

Patient is unable to sign because of:

Witness

Doctor