



# Approval Form

I /guardian of the patient.....undersigned,  
I was fully informed by the dentist about the diagnosis and treatment plan,alternative treatments, consequences Of the  
prosedure and unwanted side effects. I have accepted the treatment to be applied.

I understood and accepted that the treatment plan might change in order to new circumstances occurring during the  
treatment or the treatment period.

I was informed about the risks occurring in case of non-treatment, the extra costs of alternative treatments and that I  
could ask for consultations from other doctors if needed. I understood and accepted.

All the questions I/ guardian of the patient had about the treatment was answered fully.

I was informed, I understood and accepted that the final success of the treatment also depends on me, that I should  
follow the instructions and keep my oral hygiene, quit old bad habits, follow the instructions of dosage and period of  
using the medications as explained on the prescription.

I was informed, I understood and accepted that the treatment is to prevent my oral and dental healt, that the treatment  
will be done in an ultimate medical care but no guarantee can be given on the endresult of surgical prosedures.

I was informed about the cost of the treatment and I accept the payment.

I approve that after accepting the treatment all my / person I'm guarding radiographics, photos, videos and other  
documents can be used on educational and scientific research as anonym data.

Date: .....

Patients Name / Surname: .....

Legal guardian of the patient (\*degree) Name / Surname: .....

Passport Number: .....

Address: .....

Telephone nr: .....

Signature: .....

Dentist's Name / Surname: .....

Date: .....

Signature: .....