Kingdom of Saudi Arabia
Ministry of Higher Education
Princess Nourah bint Abdulrahman University
(048)
College of Dentistry

المَمْلَكَـــة العَرَبيَّـــة السُعُوديَّـــة
وزَارَة التَعْلِيـمْ العَالِي
جَامِعَة الأَمِيرَة نُورَة بِنْت عَبْدُالرَحْمَن
(٠٤٨)
كلية طب الأسنان

Parental Agreement to Investigation or Treatment for Adult Patients

Patient Details or Label

This treatment/procedure information document prepared for

Family name	[redacted]
First name	[redacted]
Date of birth	27-11-1993
Age	28
Gender	F
File number	10011874
Responsible health professional	Dr. Sree Lalita
Job title	Associate professor
Special requirements	

To be retained in patient's notes

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)
Extraction of tooth # 45

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: _____ Decayed tooth

Unavoidable, serious or frequently occurring risks ____bleeding, infection____

_____

☐ Blood transfusion _____

☐ Other procedure (please specify) _____

I acknowledge that I have been provided a treatment/procedure information document prepared for me. This document outlines the general treatment considerations, potential risks and hazards associated with my treatment. I, also, understand that there may be potential hazards and risks not described in the treatment/procedure information document. I have had the opportunity to discuss and clarify treatment considerations and risks with **…Dr. Sree Lalita……**. The prescribed treatment was explained to me on …27.05.2019…… I authorized student(s), resident(s) and/or faculty of university school of Dentistry to provide the outlined treatment. I further understand that, like the other healing arts, the practice of dentistry is not an exact science and that, therefore, not all complications can be predicted, and treatment results cannot be guaranteed.
Any extra procedures which may become necessary during the procedure.

Patient's Bill of Rights
The students, faculty, and staff of Exam Group School of Dentistry strive to provide high quality treatment/procedure in a patient-friendly atmosphere. As our patient, you have a right to the following:

- Comprehensive treatment that meets professional standards of care.
- Clear explanation of recommended and alternative treatment options, the risk of such treatment options and the risks of no care.
- Current information about the status of your oral/dental health and progress of care.
- Accurate information about costs prior to proposed treatment.
- Treatment with respect, consideration, and confidentiality.
- The right to ask questions about your oral/dental care at any time.
- Access to a patient representative for assistance
- Adequate information as needed to be able to give consent to proposed procedures
- Confidentiality regarding your medical conditions, oral health and records.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following leaflet/tape has been provided

This procedure will involve:
☐ General and/or regional anesthesia X Local anesthesia ☐ Sedation ☐ None

Signed [redacted] Date: 27.05.2019

Name: Sree Lalita

Job title: Associate Professor

Contact details (if patient wishes to discuss options later) # 41024

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.
Signed_____ Date_____

Name (PRINT) _____

Statement of parent/person with 'parental responsibility'
Please read this form carefully. If the procedure has been planned in advance, you should have had the risks and benefits and any alternative treatments described to you. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

√ **I agree** to the procedure or course of treatment described on this form

√ **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

√ **I understand** that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of the situation prevents this.

√ **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

√ **I have been told** about additional procedures, which may become necessary during my treatment.

I have listed below any procedures, which **I do not wish to be carried out** without further discussion.

Name [redacted]

[redacted]

Important notes: (tick if applicable)
☐ See also advance directive/living will

☐ Patient has withdrawn consent

Agreement for research purpose:

I, __ Charmaine Parina __ authorizes dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.
I consent to allow my medical information, photographs, x-rays to be used for dental records, oral/dental health research, and oral/dental health education including lectures, and professional publications. I, also, understand that my identity will be kept confidential.
Signed_____[redacted]_____Date_____27.05.2019_____

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(٠٤٨)
كلية طب الأسنان

Parental Agreement to Investigation or Treatment for Adult Patients

Patient Details or Label

This treatment/procedure information document prepared for

Family name	[redacted]
First name	[redacted]
Date of birth	23-08-1971
Age	47
Gender	M
File number	**10015366**
Responsible health professional	**Dr. Ashwag Aloyouny**
Job title	**Senior registrar**
Special requirements	

To be retained in patient's notes

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)
Gingival incisional biopsy

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: _____. Diagnosis of red and white lesion

Unavoidable, serious or frequently occurring risks ____bleeding, infection____

_____

☐ Blood transfusion _____

☐ Other procedure (please specify) _____

I acknowledge that I have been provided a treatment/procedure information document prepared for me. This document outlines the general treatment considerations, potential risks and hazards associated with my treatment. I, also, understand that there may be potential hazards and risks not described in the treatment/procedure information document. I have had the opportunity to discuss and clarify treatment considerations and risks with **…Dr. Ashwag Aloyouny……**. The prescribed treatment was explained to me on …22.01.2019…... I authorized student(s), resident(s) and/or faculty of university school of Dentistry to provide the outlined treatment. I further understand that, like the other healing arts, the practice of dentistry is not an exact science and that, therefore, not all complications can be predicted, and treatment results cannot be guaranteed.
Any extra procedures which may become necessary during the procedure.

Patient's Bill of Rights
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- Accurate information about costs prior to proposed treatment.
- Treatment with respect, consideration, and confidentiality.
- The right to ask questions about your oral/dental care at any time.
- Access to a patient representative for assistance
- Adequate information as needed to be able to give consent to proposed procedures
- Confidentiality regarding your medical conditions, oral health and records.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following leaflet/tape has been provided

This procedure will involve:
☐ General and/or regional anesthesia X Local anesthesia ☐ Sedation ☐ None

Signed _____ [redacted] _____ Date: 22.01.2012

Name: Ashwag Aloyouny

Job title:

Contact details (if patient wishes to discuss options later) # 41024

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.
Signed_____ Date_____

Name (PRINT) _____

Statement of parent/person with 'parental responsibility'
Please read this form carefully. If the procedure has been planned in advance, you should have had the risks and benefits and any alternative treatments described to you. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

√ **I agree** to the procedure or course of treatment described on this form

√ **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

√ **I understand** that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of the situation prevents this.

√ **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

√ **I have been told** about additional procedures, which may become necessary during my treatment.

I have listed below any procedures, which **I do not wish to be carried out** without further discussion.

Name___ [redacted] ___ Signature___ [redacted] _____

Date___22.01.2019_____

Important notes: (tick if applicable)
☐ See also advance directive/living will

☐ Patient has withdrawn consent

Agreement for research purpose:

I, __ [redacted] __ authorizes dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.
I consent to allow my medical information, photographs, x-rays to be used for dental records, oral/dental health research, and oral/dental health education including lectures, and professional publications. I, also, understand that my identity will be kept confidential.
Signed_____[redacted]_____Date 22.01.2019

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(٠٤٨)
كلية طب الأسنان

Parental Agreement to Investigation or Treatment for Adult Patients

Patient Details or Label

This treatment/procedure information document prepared for

Family name	[redacted]
First name	[redacted]
Date of birth	05-09-1936
Age	83
Gender	M
File number	10394049
Responsible health professional	Dr. Rasha Elserwi
Job title	Associate professor
Special requirements	

To be retained in patient's notes

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)
Routine check-up

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: _____ Routine check-up

Unavoidable, serious or frequently occurring risks ____none ____

_____

☐ Blood transfusion _____

☐ Other procedure (please specify) _____

I acknowledge that I have been provided a treatment/procedure information document prepared for me. This document outlines the general treatment considerations, potential risks and hazards associated with my treatment. I, also, understand that there may be potential hazards and risks not described in the treatment/procedure information document. I have had the opportunity to discuss and clarify treatment considerations and risks with **…Dr. Rasha Elserwi…** The prescribed treatment was explained to me on …02.04.2019…… I authorized student(s), resident(s) and/or faculty of university school of Dentistry to provide the outlined treatment. I further understand that, like the other healing arts, the practice of dentistry is not an exact science and that, therefore, not all complications can be predicted, and treatment results cannot be guaranteed.
Any extra procedures which may become necessary during the procedure.

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- Current information about the status of your oral/dental health and progress of care.
- Accurate information about costs prior to proposed treatment.
- Treatment with respect, consideration, and confidentiality.
- The right to ask questions about your oral/dental care at any time.
- Access to a patient representative for assistance
- Adequate information as needed to be able to give consent to proposed procedures
- Confidentiality regarding your medical conditions, oral health and records.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following leaflet/tape has been provided

This procedure will involve:
☐ General and/or regional anesthesia ☐ Local anesthesia ☐ Sedation ☐ None

Signed _____ [redacted] _____ Date: 02.04.2019

Name: Rasha Elserwi

Job title: Associate Professor

Contact details (if patient wishes to discuss options later) # 41024

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.
Signed_____ Date_____

Name (PRINT) _____

Statement of parent/person with 'parental responsibility'
Please read this form carefully. If the procedure has been planned in advance, you should have had the risks and benefits and any alternative treatments described to you. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

√ **I agree** to the procedure or course of treatment described on this form

√ **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

√ **I understand** that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of the situation prevents this.

√ **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

√ **I have been told** about additional procedures, which may become necessary during my treatment.

I have listed below any procedures, which **I do not wish to be carried out** without further discussion.

Name___ [redacted] Signature_[redacted]_____

Date___02.04.2019_____

Important notes: (tick if applicable)

☐ See also advance directive/living will

☐ Patient has withdrawn consent

Agreement for research purpose:

I, __ Salem Almuzal __ authorizes dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.

I consent to allow my medical information, photographs, x-rays to be used for dental records, oral/dental health research, and oral/dental health education including lectures, and professional publications. I, also, understand that my identity will be kept confidential.

Signed_____[redacted]_____Date___02.04.2019