Dr. JT (Koos) Marais B.Ch.D (Pret)
Tandarts / Dental Surgeon

Practice Limited to Endodontics / Praktyk Beperk tot Endodonsie

I, the undersigned, patient, guardian or legal representatives hereby agree that:

1. The proposed recommended treatment has been explained to me and before treatment is commenced I have been provided with sufficient information about the fees that will be charged for treatment in a way that I understand.
2. I have been informed that the fees charged by this practice are determined by the appropriateness of the quality of, standard of services rendered by this practice and practice costs and NOT based on my medical aid plan and are above the Guideline Tariffs determined by the Health Professions Council of South Africa (HPCSA) and the reasons for these fees being more than the Guideline Tariffs has been fully explained to me which I accept.
3. I have been given ample opportunity to ask any questions I may have regarding fees charged before treatment is started.

DECLARATION BY PATIENT OR GUARDIAN: I hereby declare that practitioner/s usual fees being higher than the Guideline Tariffs have been fully explained to me, which I understand and voluntarily authorize and request the dentist/s to perform the recommended treatment at the fees quoted. I also understand that it is also subject to variation and this will be explained to me. I acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any amount that it will be my responsibility to pay. I further acknowledge that I have been informed of the possible cost of any prosthetic device that may be required for the procedure. I have been advised that other health professionals may be involved in my treatment and I understand that this fees explanation/estimate does not include their fees or charges unless specifically stated otherwise.			
Patient or Guardian's signature		Date	
Guardian's full name			

I have explained to the patient, guardian, or legal representative the scope of the treatment and my fees. I also explained that my fees exceed the Guideline Tariffs determined by the HPCSA and explained what those tariff are and I believe that the information is understood.

Dentist:…Dr JT (Koos) Marais

Signature: ……………………………………………………………Date: ……………………………………..

[PO Box/Posbus 73004 Lynnwood Ridge/Rif 0040] [T] 012 9963318 [F] 086340322 [C/S] 072 200 5973
[e] koos@drkoosmarais.co.za [w] www.drkoosmarais.co.za

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. JT (Koos) Marais to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended
period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature of patient, legal guardian, or authorized agent of patient: ______________________________________

Date: ______________________________________

CONSENT FOR SURGERY

Patient Name____Date of Birth_________________________

I hereby authorize Dr JT (Koos) Marais to perform the following treatment or surgical procedure_____________________________________, and I understand that this is an elective, urgent, or emergency procedure (circle one).

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

1. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
2. Restricted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Post-operative infection requiring additional treatment.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Damage to adjacent teeth, fillings, and crowns.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

(   ) I consent to the administration of local anesthesia (Novacaine), nitrous oxide analgesia or oral sedation in connection to the procedure referred to above (circle all that apply).

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medications.

____ _____________________________________

Patient's Signature Date

____ _____________________________________

Parent or Legal Guardian (if patient under 18 yrs of age) Date

____ _____________________________________

Witness or Interpreter Date

____ _____________________________________

Dentist's Signature Date

CONSENT FOR ENDODONTIC (ROOT CANAL) SERVICES

Patient Name______________________________________Date of Birth______________________________
I hereby authorize Dr JT (Koos) Marais to perform an endodontic (root canal) procedure on tooth (teeth) _#___________________________________, and I understand that this is an elective, urgent, or emergency procedure (circle one).

Root canal therapy is indicated when the pulp chamber of a tooth is contaminated by bacteria causing the canals to become infected. The procedure is accomplished when the dentist creates a small opening in the biting surface of the tooth that will allow it to be disinfected and then sealed with an inert rubber-like substance. The sealing of the canals prevents subsequent passage of bacteria into or out of the tooth.

I have been informed that the risks to my health if this procedure is not performed may include, but are not limited to: increased pain, swelling, loss of the tooth (teeth), loss of other teeth nearby, loss of the supporting bone, spreading infection, cyst formation, and/or deterioration of general health due to systemic infection.

I have been informed of possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

- A failure to completely eliminate the infection requiring retreatment, root surgery or removal of the tooth at a later date;
- Post-operative pain, swelling, bruising, and/or limited jaw opening that may persist for several days;
- Separation (breakage) of an instrument within the canal during treatment. Broken instrument tips are typically allowed to remain in the canal, and only rarely are they the cause of subsequent problems. If removal is indicated the patient may be referred to an endodontic specialist.
- Perforation of the root from within the canal can occur requiring additional treatment by a specialist. Such complications will occasionally result in the loss of the tooth.
- Damage to nerves supplying the teeth resulting in temporary or, in rare instances, permanent numbness or tingling of the lip, chin, or other areas of the jaws or face:
- Inability to adequately clean the canal(s) due to unforeseen calcified obstructions or severely bent roots. Under certain circumstances the patient may be referred to a specialist for successful completion of the procedure. Loss of the tooth may occur:
- A fracture of the treated tooth, occurring during or after endodontic treatment. Treated teeth sometimes break due to the tooth's loss of strength resulting from the procedure. In most cases a crown is recommended after treatment to prevent such an occurrence.

Once treatment has begun, it is essential that it be completed in a timely manner. Root canal treatment will require from 1-5 appointments. Also, I understand that successful treatment does not prevent future decay or fracture of the treated tooth.

I understand the recommended treatment, the risks of such treatment, alternative treatments should any exist, and the consequences of doing nothing.

Patient's Signature____ Date__________________

Parent or Legal Guardian Signature____ Date__________________

Witness or Interpreter____ Date__________________

Dentist's Signature ____ Date__________________