Consent Form

I, the undersigned.....(name).....(date of birth)
-in case of a partially competent or fully incompetent patient, the legal representative (relative)- I, ..., certify that *Dr. József Boros* provided me with sufficient information about the following:

1. My illness, which is diagnosed as (in English, or in Latin).....
   .....
2. The recommended treatment,....., (in English) its risks, and the other available treatment options such as.....
   ..... and their known risks and consequences, he informed me about the advantages and disadvantages of the recommended and other available treatment procedures.
3. My verbal questions about the risks and possible frequent complications of the recommended treatment have been answered satisfactorily, and I have had sufficient time to freely decide on what treatment I want. I was informed that my treating dentist will always be ready to properly inform me about my status and any change in my status.

   I understand that even in the case of proper treatment, the following unforeseen complications may occur that can have a negative effect on the expected outcome (duration of healing) (to be completed by the dentist prior to signing by the patient):

   .....

   .....

   .....

   I understand that I have the right to decline any of the proposed treatments. In this case, I will release all the doctors from their own responsibility whose treatment I declined for any complication that occurs during my treatment and any change in the outcome that is related to the refusal.

   I give my consent to the treatment (surgery, etc.) based on the provided information, free of any

coercion. Accordingly, I wish the following procedure (surgery) to be performed on me:

.....

With my signature, I confirm that I do not wish to receive detailed information about the nature of my disease, the details of my treatment, and, especially, about the possible outcomes. I therefore leave it to my treating dentist to make the decisions. (This statement - if accepted - needs to be confirmed by repeating it as a handwritten text and signing it at the end of the paper. Without this confirmation statement, the waiver of information is invalid.

(Delete as appropriate.)

4.) My decision about providing information to my relatives is as follows:

Please fully inform the following relatives about my illness:

.....

.....

I have not withheld any information about my illness and previous treatments.

Tata, ...

Signature of treating dentist:

.....

Signature of patient or legal representative:

.....