



HO.RB.19 YT114.01.2015 RBV.NO:01 RBV.T: 18.04.2022 S.NO: 1/1

Dear Patient, Dear Parent/Legal Representative:

The purpose of this form is to inform you about the treatment/procedure to be performed and to obtain your consent. Please read each item carefully. While this information form describes the hairdressing process performed in clinics, it also aims to provide information about possible risks that may arise due to the procedure, treatment methods, expected benefits from the treatment, situations that may arise if treatment is not received, and the responsibilities of the patient. After reading this form, you can ask your doctor any other questions you may have about the procedure. In order for the procedure to be performed, this consent document must be read and signed by the patient. If the patient cannot give consent due to age or medical reasons, it is read, filled and signed by his/her Attorney/Legal Representative..

Tooth number to be treated:

55 54 53 52 51	61 62 63 64 65
18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38
85 84 83 82 81	71 72 73 74 75

Capping (Filling Near the Nerves)

After removing the decayed and weakened parts of the tooth, capping can be applied to your tooth depending on the condition of the remaining tooth tissue. In capping treatment, a special filling material is placed on the tooth after the decay is cleaned and the permanent filling is done in the same session or 15-20 days later.

Estimated Time of the Procedure: It is between 30-90 minutes including the examination.

Expectations from Treatment: Stopping the decay, relieving pain if present, preserving the vitality of the tooth and continuing the chewing function.

If Recommended Treatment Is Not Applied: Tooth tissue loss continues, root canal treatment or tooth extraction may be necessary.

Possible Risks: This treatment may not always be successful due to reasons depending on the regenerative ability of the tooth and the patient's oral care. If tooth pain occurs during this period and the tooth can be restored, root canal treatment is performed. Otherwise, surgical extraction treatments planned.

Things to Consider After Treatment: You can eat after the anesthesia effect (drowsiness) wears off. There may be aching and tenderness in the cold for a week. If the temporary filling breaks and falls out, the patient must return to the clinic. A detailed examination of my entire mouth was performed. In addition, in the relevant sections, physicians explained what oral and dental disease is, why treatment is needed, the risks involved, problems that may occur, alternative methods, changes that may occur after treatment, the possibility of success and the healing process.

Special Situations:You can reach the doctors of the Süleyman Demirel University Faculty of Dentistry by calling 0246 211 3334 or by calling.

APPROVAL

During the dentist's diagnosis and treatment;

Consultation can be requested from other physicians and they can participate in the treatment process, Oral, Dental and Maxillofacial Radiology doctors, trainee dentists, dental technicians and x-ray technicians can take part in my filming, my photographs, examination results (pathology report, laboratory results, etc.). It can be used for diagnostic, scientific, educational or research purposes,

Local anesthesia can be applied as a part of these procedures during the diagnostic method, intervention or treatment, and the results of the treatment are directly affected by attending the appointments without interruption and complying with the doctor's recommendations and practices regarding the treatment.

Dear Patient, To have information about your health condition and the benefits/harms, risks and alternatives of the procedures for the diagnosis or treatment recommended for you; accept or partially/completely reject treatment; You have the right to stop the transactions at any stage! This document, which we want you to read and understand, has been prepared not to scare you or keep you away from medical practices, but to inform you, determine whether you consent to these practices, and obtain your approval. This consent form consists of 1 page and was prepared in 2 copies in accordance with Article 70 of Law No. 1219 and Article 26 of the Turkish Penal Code No. 5237, one copy of which was given to the patient/legal representative of the patient.

THE TREATMENT FOR MY DISEASE WAS EXPLAINED TO ME AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT. (Note: This statement will be written below by the patient/relative in HIS OWN HANDWRITING.)

PATIENT/RELATIVE/GUARDIAN;
NAME/SURNAME:.....
DATE:.....
TIME:.....
SIGNATURE/STAMP:.....

PHYSICIAN WHO PROVIDED THE INFORMATION;
NAME/SURNAME:.....
DATE:.....
TIME:.....
SIGNATURE/STAMP:.....