DEPARTMENT OF PERIODONTOLOGY SPLINT APPLICATIONS INFORMED CONSENT FORM

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Dosya No: **BARKOD**

File Number: **BARKOD:**

Patient Name and Surname:

Dear Patient /Legal Guardian;

The purpose of this Informed Consent form is to ensure that you are informed in writing and verbally about the possible side effects that may be encountered during all procedures/applications to be applied for your treatment, to document your acceptance of the examination and treatment with knowledge of these, to obtain your consent, and to be signed.

- Whether or not to give consent to the procedure after learning about the benefits and possible risks of medical treatment is still within your own decision.
- Before starting treatment, it is important to share with your doctor whether you have had any systemic, infectious diseases, or allergies.
- Despite the high success rate of all treatments, it cannot be guaranteed, and therefore it should be understood that treated teeth may require extraction, and treatment and the disease may recur in the future.
- If you wish to exercise your right to refuse or terminate treatment, please inform your doctor.
- During working hours (8:30 AM - 4:30 PM), you can reach the clinic where you received treatment/procedure by calling 0246 211 33 47 to access medical assistance when needed, using internal extensions.
- This form is prepared in duplicate, and one copy is given to the patient. Even after your approval, if the procedure has not started, you have the right to withdraw your consent.
- For relevant opinions, suggestions, thanks, and complaints about our services, you can contact the Patient Rights Unit, drop them into the suggestion/complaint boxes at our center, submit them through the "Contact Us" section on our website.

Your Diagnosis / Preliminary Diagnosis:
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			5	5	5	5	5	6	6	6	6	6			
			5	4	3	2	1	1	2	3	4	5			
1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
4	4	4	4	4	4	4	4	3	3	3	3	3	3	3	3
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			8	8	8	8	8	7	7	7	7	7			
			5	4	3	2	1	1	2	3	4	5			

SPLINT APPLICATIONS

Procedure Description: In patients with periodontal problems, mobility in teeth may be observed due to bone loss around the tooth. Temporary and permanent splints are used to prevent this mobility by connecting the teeth. For this procedure, composite, fiber, or orthodontic wires can be used. If the teeth are permanently connected, grooves are created on the inner surfaces and/or chewing surfaces of the teeth, and the material to be used is passed through these grooves.

By whom and where the procedure will be performed: The procedure will be performed by a Specialist Dentist in Periodontology and will take place in the Periodontology Clinic.

Expected Benefits of the Procedure*:* The reduction of mobility in teeth and the restoration of the patient's function. It is applied to prevent the displacement of teeth as part of occlusal therapy, especially after acute trauma**.**

Possible Side Effects, Risks, and Complications*:* The splint may break, and tooth sensitivity may occur.

Estimated Duration of the Procedure*:* The procedure can take between 30-60 minutes depending on the size of the splinted area**.**

Patients Abbreviated Signature

Issues That May Arise If the Procedure Is Not Performed*:* Gum (gingival) disease in the area may persist. Increased mobility in the teeth, a decrease in chewing function, and tooth loss may occur as the disease progresses.

Critical Lifestyle Recommendations for Health*:* Avoid eating hard foods and refrain from biting or tearing in the treated area. Continue regular tooth brushing and the use of interdental brushes. In case of splint breakage, the patient must consult their dentist**.**

Alternative*:* There is no alternative to the procedure.

APPROVAL

I acknowledge that during the diagnosis and treatment by the dentist:

Consultations may be sought from other healthcare professionals, and they may participate in the treatment process.

Oral, Dental, and Maxillofacial Radiology doctors, intern dentists, dental technicians, and radiology technicians may be present during my X-ray sessions.

My identity information will be kept confidential, and my medical history, radiological images, photographs, and test results (pathology report, laboratory results, etc.) may be used for diagnostic, scientific, educational, or research purposes.

Local anesthesia may be administered as part of the diagnostic method, procedure, or treatment, and adherence to appointments and compliance with the dentist's recommendations and practices during the treatment can directly impact the treatment results.

I have been informed of these aspects.

I have been informed about the Implementation Communiqué issued by the Social Security Institution (SGK) regarding the relevant treatments. I have been informed that invoices related to items for which the SGK does not make payments for the materials used during the stages of the treatment need to be paid by me.

I am aware of my right to refuse or terminate treatment. I find verbal and written information sufficient. I have read, understood, and approve the "Informed Consent Form" for all examinations and treatments to be performed.

Dear Patient, Being informed about the procedures related to your health condition and the diagnostic or treatment recommendations, including the benefits/risks, risks, and alternatives, gives you the right to accept, partially, or completely reject the treatment, and to stop any procedures at any stage! This document, which we want you to read and understand, is not intended to frighten you or keep you away from medical practices; rather, it is prepared to inform you, determine whether you consent to these practices, and obtain your approval. This consent form consists of 3 pages and has been prepared in duplicate according to Article 70 of Law No. 1219 and Article 26 of Turkish Penal Code No. 5237, with one copy given to the patient/legal representative.

Patients Abbreviated Signature

DEPARTMENT OF PERIODONTOLOGY SPLINT APPLICATIONS INFORMED CONSENT FORM

I HAVE BEEN INFORMED ABOUT THE TREATMENT RELATED TO MY ILLNESS, **AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT**
(Note: This statement will be printed below in the patient's/family member's **OWN HANDWRITING**..)

…….	
THE NAME AND SURNAME OF THE PATIENT/PATIENT'S RELATIVE/ PATIENT'S GUARDIAN	THE NAME AND SURNAME OF THE PHYSICIAN PROVIDING THE INFORMATION
…….	….……
DATE:……	DATE:…….
TIME:……..	TIME:……..
SIGNATURE	SIGNATURE

Patients Abbreviated Signature