SÜLEYMAN DEMİREL ÜNİVERSİTESİ
DİŞ HEKİMLİĞİ FAKÜLTESİ

DIASTEMA CLOSURE INFORMED CONSENT DOCUMENT

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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 procedure 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 out and signed by his/her Attorney/Legal Representative.

Toot 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			

Diastema closure

Diastema closure is the process of finding a gap between two teeth that bothers the patient and filling this gap with tooth-colored aesthetic filling material. Patients generally complain about the gap between the teeth in the upper front area and want this area to be closed aesthetically.

What to Expect from the Treatment: After the treatment, the gap between the two teeth is closed aesthetically without putting pressure on the gums.

If Recommended Treatment Is Not Applied: The patient's aesthetic expectation is not realized.

Potential Risks: If the gap between two teeth is too large, when the entire gap is closed, the teeth will grow larger than they should. In this case, some space can be left in between to prevent the teeth from growing too large. After closure, the filling may fall or break. In the worst case scenario, the patient returns to his previous state.

Things to Consider After Treatment: The patient should no longer bite hard foods such as bread, carrots and apples with his front teeth, but should eat them by dividing them. One should be careful about trauma to the frontal area.

Treatment Duration: Approximately 30 –60 min.

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 situations that may occur during the healing process.

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

APPROVAL: During the dentist's diagnosis and treatment;

Consultation can be requested from other physicians and they can participate in the treatment process,

Intern dentists will participate in diagnosis and treatment and will work under the supervision of assistants and faculty members.

Oral and Maxillofacial Radiology doctors, intern dentists, dental technicians, and x-ray technicians can take part in the filming process,

My identity information is kept confidential and my anamnesis information, radiological images, photographs, and examination results (pathology report, laboratory results, etc.) can be used for diagnostic, scientific, educational, or research purposes,

Local anesthesia may be applied as a part of these procedures during the diagnosis method, intervention or treatment, and attending the appointments without interruption and complying with the doctor's recommendations and practices regarding the treatment may directly affect the treatment results,

It was explained to me.

I know that I have the right to refuse or terminate treatment. I find all verbal and written information sufficient. I have read, understood, and approved the "Informed Consent Form" for all examinations and treatments.

Dear Patient, you have the right 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 consent. This consent form consists of 1 page and has been prepared in 2 copies in accordance with Article 70 of Law No. 1219 and Article 26 of the Turkish Penal Code No. 5237, and one copy has been 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 in the patient's/relative's **OWN HANDWRITING**.)

…….

NAME/SURNAME OF THE PATIENT /RELATIVE /GUARDIAN	NAME/SURNAME OF THE PHYSICANS WHO PROVIDED THE INFORMATION
:……..	……..……
DATE:……	DATE:……
TIME:……..	TIME:……..
SİGNATURE:……..	SIGNATURE:…….