SÜLEYMAN DEMİREL ÜNİVERSİTESİ
DİŞ HEKİMLİĞİ FAKÜLTESİ

LOCAL ANESTHESIA INFORMED DOUMENT

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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.

Tooth No. Where Local Anesthesia Will Be Applied:

			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			

Local Anesthesia:

It is the temporary blocking of a certain area of the nerves that transmit sensation in the human body, with anesthetic substances (lidocaine, mepivicaine, etc.). Local anesthesia is applied to provide pain control during dental procedures. If necessary, first the gums or the inside of the cheek are anesthetized with a topical anesthetic (spray).

What to Expect from Local Anesthesia: The aim is to prevent pain by anesthetizing the area to be treated during the interventions and therefore to treat the patient without feeling any pain. Duration of loss of sensation as a result of the local anesthesia used; It varies between 1-4 hours depending on the anesthetic agent used, the area where anesthesia is applied and the anatomical structure of the person. Average processing time; It is 5 minutes.

If Local Anesthesia is Not Applied: If local anesthesia is not applied, the procedures either cannot be performed because they will be too painful, or they are performed under more complicated sedation/general anesthesia.

Potential Risks: If you are pregnant, have any systemic disease or allergic condition, you should definitely inform your doctor who will perform the procedure. Excessive use of alcohol can reduce the effect of anesthesia. Temporary loss of consciousness, called syncope (fainting), may occur due to fear, excitement or hunger. Difficulty in opening the mouth, called trismus, may occur, which will resolve spontaneously within 2-3 weeks. Pain or edema may occur during anesthesia. Pain may occur at the injection site (up to 1 week). Side effects such as temporary facial paralysis, temporary strabismus, temporary blindness, muscle weakness, difficulty swallowing, numbness of the earlobe, nose and tongue, swelling or facial color change may occur due to the nerves adjacent to the anesthetized area being affected. These resolve completely when the effect of anesthesia wears off. If the patient scratches, bites, or chews the anesthetized area, he or she may create a self-inflicted wound. Anesthesia may sometimes not provide the desired numbness and in this case it may need to be repeated. Although very rare, a severe allergic reaction that affects all tissues and organs in the body may occur.

Things to Consider After Treatment: The area where local anesthesia is applied is numb for approximately 1-4 hours. For this reason, eating and drinking is not recommended until the numbness subsides to prevent wounds on the inside of the cheek and lips due to biting.

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:…….

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