SÜLEYMAN DEMİREL ÜNİVERSİTESİ
DİŞ HEKİMLİĞİ FAKÜLTESİ

TOOT RESTORATION 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			

RESTORATION

It is the process of replacing the hard tissues of the tooth that are lost due to caries, trauma, wear, etc., with special filling materials similar to the tooth structure in order to restore the tooth's normal function and appearance. Depending on the distance of the decay from the tooth pulp, hot/cold sensitivity and pain may occur. This complaint may decrease or increase in a few months or less. If it increases, it is not due to a bruise being left under the filling; It may be caused by the deterioration of the pulp due to the effects of stimuli. In this case, root canal treatment is performed.

What to Expect from the Treatment: It is to stop the progression of decay, relieve pain, if any, and brougt in the function and aesthetics of the tooth.

If Recommended Treatment Is Not Applied: The loss of tooth tissue continues, the tooth structure weakens, the tooth may break, pain may occur in the tooth, and may progress to root canal treatment and extraction of the tooth.

Potential Risks: Depending on the condition of the tooth and the patient and the patient's oral care, treatment may not always be successful. Depending on the size of the decay, tooth breakage, the filling falling out, breaking, discoloration, and re-occurrence of decay around the edges of the filling if oral hygiene is not taken into consideration. Cold-hot sensitivity and pain depending on the distance of the bruise to the nerve. During the treatment, the nerves (pulp chamber) may be opened or broken, root canal treatment may be required due to problems that cause severe pain and inflammatory reactions after filling in deep caries, ongoing sensitivity and allergic reactions to some restoration materials after the filling, failure to meet the aesthetic expectations of the patient after the restoration of the tooth. Possible complications include damage to tissues such as cheeks and lips by the tips of the high-speed heads during treatment, and temporary sensitivity after filling.

Things to Consider After Treatment: You can eat after anesthesia has passed and a few hours after amalgam fillings. In the first ten days, the tooth may experience mild pain and sensitivity to hot and cold temperatures. If the complaints do not go away and continue to increase, the clinic should be consulted again.

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**.)

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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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