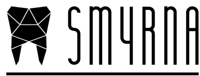

SMYRNA DENT

APICAL RESECTION/BISECTION OPERATION INFORMED CONSENT FORM

The objective of this form is to enable your participation into the decision making process about your healthcare by informing you.

This form has been designed in order to meet the needs of many patients under most conditions, nevertheless, it should not be considered as a document containing the risk of the entire applicable treatment. Based upon your individual healthcare, your physician may provide you with different or additional information.

After acquiring the advantages and possible risks of diagnosis, medical treatment and surgical interventions, it is up to your decision whether or not to accept these procedures. You are entitled to refuse to be informed except for the legal and medical necessities or withdraw your consent at any time.

What You Need to Know About Your Disease

The healing potential of your gingiva and jaw bone cannot be predicted after the procedures due to difference in individuals with healing capacity. The apical resection/bisection operation you are going to have may fail in some cases, loss of teeth may occur; therefore the treatment outcome cannot be guaranteed.

Smoking, alcohol and sugar consumption may impair your gum healing and limit the success of the procedures performed.

You should give detailed information to your physician about your physical and mental health within your knowledge. You should also inform your physician about pre-existing allergic reactions to food, anesthetics, pollen or dust; systemic diseases; skin and gingival reactions; abnormal bleeding tendency and other conditions related to your general state of health.

Risks Related to Procedure

The risks that may arise from treatments performed or the risks during the procedures that may arise due to surgery, anesthesia or recommended medications:

- Complications such as numbness, pain, swelling, infection, coloring and sensitivity in the lips, tongue, chin, cheek and teeth may occur.
- Differences may occur during and after treatment at the gingival margin level and there may be changes in appearance due to that condition.
- In addition to these, delay in healing, damage to teeth, allergies to the recommended medications, and jaw joint problems may develop after the procedure that will be performed.

Additional or different applications may be required during or after the operation, such as tooth extraction, root canal therapy, biomaterial application.

What May Happen If the Procedure Is not Carried Out?

If you do not agree with the recommended treatments and interventions, gingivitis, bone loss, infection, sensitivity in the teeth or loosening, loss of teeth, and problems with chewing and jaw joint functions due to these conditions may occur.

SMYRNA DENT

Diagnosis____

Treatment/procedure to be applied____

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

____

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's			
Full Name:	Signature:	Date:	Time:
Date of Birth:			
Legal Representative's			
Full Name:	Signature:	Date:	Time:
Degree of Relationship:			
Reason why the consent is delivered by legal representative of the patient:			
☐ Patient is not conscious	☐ Patient is under 18		
☐ Patient is not entitled to make decision	☐ Emergency		
Witness'			
Full Name:	Signature:	Date:	Time:
Informing Physician's			
Full Name:	Signature:	Date:	Time:
Interpreter's (If required)			
Full Name:	Signature:	Date:	Time:

Informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together with his/her legal representative if the patient is aged between 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.