



SMYRNA DENT

ORTHODONTIC TREATMENTS 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 Health Impairment:

As a result of the examinations and evaluations carried out, it is determined that your orthodontic problem is

Recommended Treatment

- **Without extraction:** The planned treatment for your orthodontic problem is briefly summarized below:
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.....
.....
- **With extraction:** There is not enough space for your teeth to be aligned properly in your jaws. Orthodontic treatment with extraction is required to overcome the problem of lack of space. The teeth that your dentist sees medically fit are needed to be extracted. Therefore, a total of teeth are planned to be extracted from the region. The cavities obtained by tooth extraction will be replaced with the teeth outside the denture.

Your orthodontic treatment consists of two stages which are active and passive, and the duration of treatment may vary depending on the severity of the disease.

Retaining elements (orthodontic bracket) will be bonded on the teeth for treatment purpose and wire retainers will be threaded through these brackets. When required, support screws placed on the jawbone; threaded devices that expands the jaw; metal springs, rubber chains, etc. may be used. Occasionally, it may be necessary to use extraoral devices (devices such as cervical headgear/ facial masks) or internal/external rubber rings that must be inserted and removed by the patient. During your treatment, your dentist may place some devices that he/she sees fit into your upper and/or lower jaw or out of the mouth. It is important that you follow the instructions on their usage exactly.



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At the end of every orthodontic treatment, there is a tendency of the teeth to move and return to their initial position in the treatment. Therefore, as soon as the active orthodontic treatment is completed, the retention treatment, which is a passive orthodontic treatment, should be started. In this treatment, either a fixed wire is bonded on the inside of the teeth or a retainer is used that the patient can wear and remove. The use of the removable device in accordance with the dentist's instructions is crucial to ensure permanent treatment result.

Risks Related to Procedure

You may experience some problems during orthodontic treatment. In order to overcome these problems, it is important that you follow the rules of the treatment , keep the appointments regularly and cooperate with your dentist.

- Metal and rubber devices on the teeth may cause a temporary difficulty in eating, speaking and swallowing.
- Scarring may occur on the lips, cheeks and tongue.
- Oral health care may become difficult.
- Unintended consequences such as detachment of the brackets, breakage of the wires may occur. The duration of treatment may extend if it is not maintained.
- During orthodontic treatment, root shortening (root resorption) may occur in some patients. If there is a serious shortening, treatment may be terminated by the dentist.

Considerations During the Treatment

During treatment, caries may occur in teeth that are not sufficiently brushed, and permanent white spots and gingivitis may develop. Therefore, you should brush your teeth regularly after the main meals and snacks until you are sure that you have removed all food residues.



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Diagnosis _____

Treatment/procedure to be applied _____

Side/grade if applicable Right sided Left sided Both sided Grade _____

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:			
<input type="checkbox"/> Patient is not conscious	<input type="checkbox"/> Patient is under 18		
<input type="checkbox"/> Patient is not entitled to make decision	<input type="checkbox"/> 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.