SMYRNA DENT

RETENTION AFTER ORTHODONTIC TREATMENT
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.

Treatment to be Applied

After every orthodontic treatment, movement of teeth and returning to the former condition may occur. Therefore, as soon as the active orthodontic treatment is completed, "retention treatment", a passive orthodontic treatment, is of great importance. Retainer wire adhered to the internal section of the teeth for retention treatment or removable plaques should be used for at least 2 years.

Usage and Maintenance of Plaques

Except the meal periods, you should wear the removable plaques all day long. These plaques should be avoided from all pressures in order to prevent them from being deformed and leaked as they are so thin. When the plaque is inserted into your mouth, nothing should be eaten, except water no other fluids with sugar, gas and hot beverages should be consumed thereby avoiding the compression, and squeezing. Each time the plaque is removed from mouth, it should be cleaned with water, and it should be protected inside the box you receive and during eating, it must never be wrapped with napkin and/or tissue. The plaque should be cleaned with a new tooth brush which is never used beforehand by applying hand soap but not tooth paste, from its internal section. As tooth paste causes the loss of transparency feature of the plaque, it must not be used.

You are held responsible for using the plaques in an approach not to move the teeth and allow the treatment to return to the former condition. You should apply to your attending dentist in the event that fixed retainer wire or removable retention plaques are broken or lost. Broken plaques or broken retainer wire may be replaced by paying its charge.

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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.