Erciyes University

Faculty of Dentistry
Oral and Maxillofacial
Surgery Hospital

Information Consent Form

Patient's name and surname:
Date of birth:
File number:
Gender:
Phone number:
Diagnosis:
Treatment options:

- ☐ ……
- ☐ ……

☐ Local anesthesia ☐ sedation ☐ general anesthesia

Risks associated with treatment:

- ☐ Pain and swelling that will require rest at home after the operation
- ☐ Bleeding that may continue for a long time
- ☐ Damage to adjacent teeth, fillings or dentures
- ☐ Infection that occurs after the operation and requires additional treatment
- ☐ Failure of treatment, need for retreatment, or worsening of the current condition
- ☐ Cracks or wounds in the corner of the mouth due to stretching of the mouth corners
- ☐ Leaving the broken root/roots when necessary
- ☐ Broken jaw
- ☐ Temporary or permanent numbness in the lips, tip of the jaw, gums, cheek, teeth and/or tongue
- ☐ Additional surgical interventions are required as a result of the sinus (the space in the jawbone above the teeth in the upper jaw) becoming associated with the mouth.
- ☐ Temporary or permanent paralysis of facial nerves
- ☐ Scar formation on the gums and/or face
- ☐ Development of situations that may be life-threatening and require emergency treatment due to the drugs administered
- ☐ Tooth loss
- ☐ Other……

As Dr……, I explained the procedure to be done to the patient himself / his mother / father / his person in charge / his representative. I specifically stated that:

- ☐ Expected benefits
- ☐ ……
- ☐ ……
  - ☐ Other procedures that may be requested later during the surgery:
  - ☐ Blood transfusion
  - ☐ Other operations (please specify):……

I also explained what the procedure involved, the benefits and risks of alternative treatment methods (including no treatment), and other conditions specific to the patient.

Doctor's Name-Surname: Signature:
Date:

Translator (if needed);
Name Surname: Signature

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Please read this form carefully. If your treatment is planned in advance, you should have a copy of the front page that explains the benefits and risks of the treatment. Otherwise, grab a copy now. If you have any other questions, please ask. You have the right to change your mind at any time, including after you sign this form and until you undergo surgery.

1. I accept, in my right mind, the form and course of treatment specified in this form.
2. I have provided all information about my general health condition and I acknowledge that I have been informed about any problems that may arise due to this condition.
3. I agree to fully comply with my doctors' recommendations and understand that otherwise my treatment may result in failure.
4. I acknowledge that any tissue (including blood) removed during the procedure or treatment may be used for diagnosis and examination and will be stored or disposed of appropriately and will be handled in accordance with appropriate ethical, legal and professional standards.
5. I accept that tissues (including blood) that are not required for my own diagnosis and treatment may be used for educational and genetic research purposes.
6. I understand that each study is approved by an ethics research committee and is assured of appropriate ethical, legal and professional standards.
7. I understand that all research is conducted by a university or hospital and not by a for-profit organization or company.
8. I agree to have photographs taken for diagnosis and treatment purposes.
9. I agree to use the photographs taken for educational purposes without identifying myself.
10. I understand that you do not guarantee that a specific person will perform my treatment. Anyway, the person who will perform my treatment will have sufficient experience.
11. I understand that I can talk to the anesthetist about the details of the anesthesia before the procedure, as long as the urgency of my situation allows it (only for patients who will undergo general and regional anesthesia).
12. I understand that any action other than those specified in this form may only be taken to save my life or to prevent serious harm to my health.
13. It was explained to me that other procedures may need to be performed during my treatment. Below I have stated the operations that I do not want to be performed without my permission.

……
……

I HAVE READ THIS FORM AND UNDERSTAND ALL THE TERMS AND WORDS CONTAINED.

Name-Surname of the Patient/Parent: Signature:
Date: