**TOOTH EXTRACTION PATIENT INFORMATION AND CONSENT FORM**

**What you need to know**

Since there is a difference between individuals in terms of their healing potential, the healing potential of a person cannot be predicted before the procedure. Since the treatment to be applied to you may fail in some cases, it may need to be repeated and the result of the treatment cannot be guaranteed. You should give your physician detailed information about your physical and mental health to the best of your knowledge. You should also inform your physician about any previous allergic reactions to medication, food, anaesthetic substances, pollen or dust; systemic diseases; skin and gum reactions; tendency to abnormal bleeding and other conditions related to your general health.

It is the extraction of teeth that cannot be treated due to caries, advanced gum disease, prosthetic / orthodontic / prophylactic and other reasons. This procedure is usually performed under local anaesthesia. Tooth extraction is an irreversible treatment. It affects your biting and chewing functions. For this reason, these losses are eliminated with a type of prosthesis made to replace the teeth lost after extraction. Before deciding on tooth extraction, you will be offered all appropriate treatment options (root canal treatment, gingival surgery, crown or filling). However, in some cases, tooth extraction may be the only option.

Action to be performed: ……………………………………………………………………………………………………………………………………………………………………….

**Interventional Risks, Recommendations and Complications**

- Temporary swelling, redness, bruising and numbness of the cheek may rarely occur due to anaesthesia.

- Discomfort or swelling that may require a few days of home rest may occur.

-Temporary restriction of mouth opening and closing movements may occur.

-Temporary discolouration and redness may occur on the face in the extraction area.

-Mild / moderate / heavy bleeding may occur, which may last longer.

-Temporary or, very rarely, permanent numbness (tongue, lips, jaw tip) may occur in the nerves of the extraction area.

-Temporary loss of taste sensation may occur.

-Fracture, displacement or dislocation of restorations (fillings, crowns) in neighbouring teeth, shaking or damage to the neighbouring tooth may occur.

-Cracks may occur in the corners of the mouth due to opening the mouth too much.

-Sinus opening may occur in the extraction of the upper teeth.

-Temporary discomfort may occur in the jaw joint.

-In the extraction of very difficult and deeply embedded teeth, cracking or fractures in the jawbone may occur, although it is very rare.

-After extraction, irregularities in the jaw bones (which can be corrected with a separate surgical treatment) may occur.

-During extraction, part of the tooth root may break and remain in the bone or escape to the surrounding tissues (in this case, additional advanced surgical procedure may be required).

-Pain or infection may occur after extraction. Your dentist may prescribe antibiotics, painkillers (anti-inflammatory analgesics) or mouthwash before or after tooth extraction. You must use these medicines as prescribed.

-Avoiding harmful habits such as smoking and drinking alcohol after the extraction may delay wound healing. It may cause inflammation of the extraction cavity.

I am. .............................................................. , I accept the treatment to be applied by the physicians of Clinic Nişantaşı Oral and Dental Health Polyclinic as I am of sound mind. The treatment options that can be applied for the treatment of my discomfort have been presented to me. I consent to the administration of all necessary medications and interventions during the fulfilment of the treatment option I have chosen for the treatment of my condition. I have given all information about my general health condition and I have been informed about the problems that may arise due to this condition. I agree to fully comply with the recommendations of the doctors and I know that otherwise my treatment may result in failure. I consent to the use of the information to be obtained during my examination and treatment with other scientific institutions or for education (provided that it complies with patient rights and ethical principles) for research for the development of science.

**I HAVE READ THIS FORM AND UNDERSTAND ALL THE TERMS AND WORDS IN IT.**

**Date:**

(Please write in handwriting: I have read, I understand, I accept**)**

**Signature:**

**Signature:**

**Signature:**

**Patient's Name-Surname:**

**Patient's Parent/Guardian Name-Surname:**

**Physician Name-Surname:**