**PATIENT INFORMATION AND CONSENT FORM FOR ROOT CANAL TREATMENT**

**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.

Root canal treatment is the process of removing the nerve tissue exposed in the tooth broken as a result of decay reaching the nerve or impact, including the nerve in the roots, and filling the tooth canal with artificial materials. The nerves causing pain are removed under anaesthesia and the tooth is filled. In cases where this treatment is necessary but not applied, severe pain, infection and tooth loss may develop.

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

**Disorders and complications that may occur due to the intervention**

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

- Small parts of the materials used during the treatment may be swallowed without the control of the physician.

- During the treatment, soft tissues may be injured due to involuntary movements of the patient.

- Root canal treatment is the last treatment tried to keep the tooth in the mouth. The alternative to root canal treatment is repeat root canal treatment, and if that fails, tooth extraction.

-There may be pressure pain for a few days in the root canal treated tooth. Drugs recommended by the physician should be used.

-In cases such as severe pain or facial swelling, the physician should be informed.

-Very hard foods should not be consumed until the treatment is over.

-During the procedure, the canal tool may remain in the canal.

-Sensitivity to canal washing solutions may develop.

-The fragility of the tooth may increase after decay cleaning and root canal treatment.

-After root canal treatment, there may be pain during chewing for 7-10 days, it may last longer in cases of stubborn infection, and may even require a repeat root canal treatment.

In cases where structural problems in the tooth cannot be detected by X-ray, extraction of the relevant tooth may be required during the treatment phase.

-In teeth for which root canal treatment is started, extraction of the tooth may be required due to blocked canals, excessive loss of material, root cracks and fractures, etc.

-During canal filling, the canal filling material may be missing or may come out of the root tip due to unavailable reasons.

-In cases where a previous canal treatment needs to be renewed, sometimes the old canal filling may not be completely removed, an ideal filling may not be made up to the root tip, and as a result, canal treatment may fail.

-The number of sessions of root canal treatment depends on the condition of the tooth. Sensitivity may be observed between sessions or after the end of treatment.

-Restorations (crowns, bridges, fillings, etc.) on the tooth to be treated can be removed if necessary, after which the restorations may need to be renewed.

X-rays may be taken at certain stages of the treatment. The responsibility arising from the failure of pregnant patients to inform the physician about this issue belongs to the patient.

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 TERMS AND WORDS IN IT. Date:**

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

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**Signature:**

**Signature:**

**Signature:**

**Patient's Name-Surname:**

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

**Physician Name-Surname:**