**RESTORATIVE DENTAL TREATMENT 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; abnormal bleeding tendency and other conditions related to your general health.

Dental filling is the process of cleaning the decayed tooth tissues and filling their place with artificial materials to ensure tooth integrity.

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

**Interventional Risks, Recommendations and Complications**

- Treatments that do not require anaesthesia may be only partially painful.

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

- Metal bands and wooden wedges used during filling may traumatise the gum and cause sensitivity.

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

- Soft tissues may be injured due to involuntary movements of the patient during treatment.

- In case of progression of caries in the tooth where filling treatment is started, canal treatment may also be required.

- Complications such as pain and sensitivity may occur after filling. Root canal treatment may be required in persistent pain. It should be kept in mind that temporary pain may continue for 2-3 days and cold sensitivity for 3-4 weeks.

- In cases where there is excessive loss of tooth tissue to be sufficiently bonded, the filling may fall out.

- After filling, fracture of the tooth may occur due to loss of material in the tooth. In order to prevent this situation, your dentist may also recommend that the relevant tooth be coated.

- Since the tooth colour of each patient is different and the aesthetic fillings we use are not exactly the same as the tooth tissue, sometimes the desired tooth colour may not be fully achieved and there may be a slight difference in tone.

- The tooth colour, which is satisfactory immediately after aesthetic fillings, may change over time. The filling may need to be renewed after a few years.

- After aesthetic fillings made to the front teeth and fillings made to the posterior group teeth, the filling may fall or break as a result of the forces coming to the front teeth with the function of biting and tearing.

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:**