GENERAL CONSENT FORM

Signed below, I/the patient's guardian …………………………………………………………………………….,

Dentist ……………………………………………………………………………… I was informed about the diagnosis and treatment planning, alternative treatments, results, undesirable side effects, I understood. I have accepted the treatment that will be applied.

I was told that planning may change with new situations that may arise during/during treatment, I understood and accepted.

I was informed about the possible risks that may arise if the treatment is not applied, cost calculations according to alternative applications of my treatment, that consultations may be requested from other physicians if deemed necessary, I understood, I accepted.

All the questions I was curious about my treatment/ the treatment of the person I am a guardian of have been answered. I was told that the success of the treatments depends on me, that I should follow the oral cleaning and recommendations that fall on me at home, that I should fulfill the recommendations about harmful habits that should be abandoned and use the medications in the prescriptions to be written in doses and durations appropriate to the recipe,I understood and accepted.

I was told that the treatments to be applied were aimed at protecting oral and dental health, that medical services would be carried out with care, but that the result could not be guaranteed in medical procedures, I understood and accepted.

As mentioned above, I have approved and accepted dental treatments that were explained to me/the person I am a guardian of during the treatment planning and accepted by me.

I was informed in detail about patient rights and responsibilities, physician rights and obligations.

After accepting the treatment, I authorize the use of radiographs, photos, videos and other documents belonging to me/ the person I am guardian as anonymized data in educational and/or scientific studies. Permission to share my personal data with third parties and institutions, including public institutions and organizations……………………. (Write “I give” or “I don't give” in your handwriting.)

………………………………………………………… Write “I understood what I read, I accept” in your handwriting.

Date :……………………………..

Patient Name-Surname:…………………………………………

Legal Representative of the Patient(\* - Degree of Closeness) Name-Surname:…………………………………………

T.C. ID Number : ………………………………………………….

Address : …………………………………………………………

Phone : ………………………………………………………………

Signature : ………………………………………………………………….

Doctor's name and surname : ………………………………………………

Date : ………………………………………………………………….

Signature : ………………………………………………………………….

\*Legal Representative: Guardian for persons under guardianship, parents for minors, in cases when they are absent, relatives of the 1st degree (Indicate the degree of closeness next to the name of the patient's relative.)

CHANGES IN THE TREATMENT PLAN

…………….. changes have been made to the treatment plan made on the date indicated below.

TEETH

Diagnosis

PLANNED TREATMENT

My dentist explained why a treatment change is necessary, the risks it involves, problems that may occur, alternative methods, changes that may occur after treatment, the probability of success and events that may occur during the recovery process.

Accepting the change in the treatment plan mentioned above ………………….(Write “I do” or “I don't” in your handwriting.)

Name-Surname Signature Date/Time

Patient / Patient's Legal Representative (\*)

-degree of closeness

The Physician who makes the information

Translator (if used)

\*Legal Representative: Guardian for persons under guardianship, parents for minors, in cases when they are absent, relatives of the 1st degree. (Indicate the degree of closeness next to the name of the patient's relative)