Dear Patient / Legal Representative;

To be informed about your health condition / your patient's health condition and all kinds of medical, surgical or diagnostic procedures recommended for you / your patient and their alternatives, benefits, risks and even possible harms, and to reject, accept all / some of them or the procedures to be performed. You have the right to stop at any stage. This document, which we want you to read and understand, has been prepared not to scare you or keep you away from medical practices, but to inform you and obtain your consent in determining whether you will consent to these practices. Before deciding whether to accept the oral and dental health services and recommended treatment offered by our center, all kinds of treatment and examination procedures are subject to patient permission and approval in accordance with **Article 14 of the Medical Deontology Regulation**. Before starting treatment, if the patient has systemic disorders (**heart, diabetes and blood disease, blood pressure, goiter, epilepsy**, etc.), **an infectious disease** (**hepatitis**, etc.), is receiving **chemotherapy or radiotherapy, is pregnant or suspected of being pregnant, has asthma or is allergic to any drug,** if any. It is important for both his own safety and the physician to share the medications he uses with his physician.
Please read the information form below carefully about the treatments to be applied by your dentist and sign the form. Ask your doctor to explain anything you do not understand.

TO INFORM

PRELIMINARY DIAGNOSIS: : …… ……..

PLANNED TREATMENT/PROCEDURE:……

NAME/SURNAME OF THE PHYSICIAN WHO WILL PERFORM THE PROCEDURE:…….

INFORMATION ABOUT THE TRANSACTION:

• ARTHROCYNTHESIS application is a pressurized washing process by entering the upper cavity of the jaw joint with a needle from the outside, using local anesthesia for jaw joint patients, as some pathologies in the lower jaw joint manifest themselves as pain in the jaws/teeth/ear, limitation in opening the mouth, and noise in the joint.
• Factors include trauma, stress, faulty practices (faulty dentistry practices: wrong filling, prosthesis or faulty habits of the patient; eating ice, cracking nuts, etc.).
• In arthrocentesis application, two needles are inserted into the joint cavity from the area in front of the ear into the jaw joint, the patient's joint is washed with pressurized fluid, and when necessary, hyaluronic acid, a type of lubricating substance, is injected.
• The mechanism of action of arthrocentesis has not been clearly revealed. However, its soothing effect on joint pain has been shown by scientific research. It is a preferred method for persistent pain or inflammatory conditions.

EXPECTED BENEFITS FROM THE PROCESS:

• JOINT PAIN is corrected; Pain in and around the joint is the most common symptom. It usually occurs when the jaw is opening and closing, but it can also occur at rest.
• HEADACHE disappears; Various degrees of headache may occur in most joint patients. Muscle tension is often accompanied by long-lasting headaches and can cause pain in situations such as chewing, speaking and swallowing.
• JOINT SOUND is corrected; Joint patients often hear clicking and crackling sounds. Clicking sounds are very common in society and rarely produce significant consequences. However, rustling sounds indicate that the structure of the joint and disc may be damaged and are a more serious condition. Regardless of the sound found, we recommend that you be examined by a maxillofacial surgeon in terms of treatment needs.
• DIFFICULTY IN OPENING AND CLOSING THE JAW is corrected; As the jaw opens, the joint makes a sliding movement forward and downward. This movement is expected to be smooth, painless and silent. However, if the disc is positioned forward than normal, symptoms such as pain, shifting to one side when opening the mouth, and restriction in mouth opening may occur.
• DIFFICULTY IN CHEWING AND BITEING improves; One of the main symptoms of TMJ disease is pain during chewing and biting. Additionally, it becomes difficult to perform activities such as eating and chewing.

CONSEQUENCES THAT MAY BE ENCOUNTERED IF THE PROCEDURE IS NOT IMPLEMENTED:

• If the procedure is not performed, your complaints of earache and ringing, pain felt in the cheeks and temples, difficulty in opening and closing the jaw and noise when opening and closing it, jaw locking, difficulty in closing the lower or upper jaw, and headache will increase or continue.

ALTERNATIVES TO THE PROCEDURE, IF ANY:

• Night plate can be applied to patients who have problems such as clenching or grinding their teeth.
• Treatment planning can be done with medication and physical therapies suitable for the jaw muscles. If the pain occurs too much, washing the inside of the joint will reduce the pain.
• If there are conditions such as trauma or tumor in the jaw, surgical procedures can be applied.
• If your treatment is necessary, ENT doctors, physical therapy department and dentists can work on common ground and plan treatment.

RISKS AND COMPLICATIONS OF THE PROCEDURE:

• Procedure-related complications; may occur.
• Depending on the drug used (for example, the drug Orthovisc is produced from chicken comb), there is a risk of allergic reactions, injection risks and the risk of damage to adjacent anatomical structures. These risks are low-probability risks and may require additional procedures.
• Other complication risks that are common and usually resolve spontaneously in a short time are swelling in the area after arthrocentesis. The reason for this may be physiological saline leaking into the tissue, hematoma (accumulation of blood within the tissue).
• Although it is not common, ecchymosis (bruising) may also occur in the area and this will disappear spontaneously in about 1 week.
• Bleeding may occur during or within a few weeks after surgery. Due to bleeding during the surgery, the surgery can be terminated by tamponade. Packing with local anesthesia or another surgery may be required to stop bleeding after surgery.
• Headache may occur during and after the procedure. There may be a general discomfort after the operation. There may be swelling that may require other additional treatments. The slight discomfort that may occur after the procedure usually goes away without any problems with the routine use of painkillers.
• Injuries may occur to the nerves that control facial muscles. This condition may develop either immediately after the surgery, due to the complete cutting of the nerves during the surgery, or a few weeks after the surgery, due to edema or pressure around the nerves. In both cases, it may be permanent.
• Visual impairment or blindness may occur. There may be damage to the tear glands or ducts.
• There may be damage to the salivary glands or ducts.
• Restriction in opening the mouth during recovery; This may occur due to swelling or muscle damage, or it may develop as a result of stress on the joint if there is a jaw joint problem. There may be a fracture in the jaw bone.
• There may be injury to the nerve extending under the teeth in the lower jaw; Accordingly, there may be pain, numbness, tingling and sensory disturbances in the cheeks, lips, tip of the jaw, gums and tongue, which may persist for several weeks, several months or, in rare cases, permanently.

ESTIMATED DURATION OF THE PROCESS:

• The procedure time varies depending on the extent and complexity of the operation and complications during the procedure, but it can take between 30 minutes and 1 hour on average.

POSSIBLE UNDESIRABLE EFFECTS OF THE DRUGS TO BE USED AND POINTS TO BE CONSIDERED:

• The hyoloronic acid used during the procedure may cause an allergic reaction. Because
• An allergic reaction may occur to the active ingredients contained in these agents.
• You will need to use some medications during and after the procedure. Your doctor may recommend antibiotics, painkillers or mouthwash before or after the operation. You must apply these medications as directed.
• Your doctor may recommend antibiotics, painkillers or mouthwash before or after the operation. You must apply these medications as directed.

THINGS THE PATIENT SHOULD CONSIDER BEFORE AND AFTER THE PROCEDURE:

• The procedure can be performed locally/regionally/infiltratively. Therefore, take **aspirin, vitamin E, coenzyme Q, etc. for 3 days before the procedure**. You should not take blood thinners such as: If you are using medication or similar substances, or if you have an infectious disease such as AIDS, Hepatitis B/C, or a problem such as diabetes, heart, high blood pressure or kidney failure, you must inform your doctor.
• After the application, nothing should be eaten or drunk for 2 hours, soft and warm foods and drinks should be taken in the first days, the mouth should not be opened too much, one should not talk for too long, gum should not be chewed, and one should not smoke for 3-4 weeks after the procedure.
• You should not sit with your hand on your chin, you should lie on your back and not on your side or face.
• Splint use should be continued for another 6 months after the clenching and pain have stopped and should be left under the supervision of a physician.

PROBLEMS THAT MAY OCCUR IF NOT PAY ATTENTION TO THE POINTS THAT MUST BE FOLLOWED:

• Your doctor will inform you about the problems you may experience if you do not pay attention to the precautions.
• After the procedure, you must follow the doctor's recommendations to protect yourself from infections.
• After the procedure, you can start eating at the time allowed by your doctor. Follow your doctor's recommendations (exercise, nutrition program, etc.).

HOW TO REACH MEDICAL HELP ON THE SAME ISSUE IF NECESSARY:

• Not accepting treatment/surgery is a decision you will make with your free will.
• If you change your mind, you can personally reapply to the clinics/hospitals that can perform the treatment/surgery in question.
• In case of possible side effects related to the practices performed in our institution, emergency interventions will be carried out by the responsible physician and relevant healthcare personnel. If you encounter any complications; You can apply to our clinic without an appointment. **Phone: +90 232 330 04 67/68**

• Medical research: Reviewing clinical information from my medical records for the advancement of medical study, medical research, and Physician education; I give my consent provided that the patient confidentiality rules in the patient rights regulation are adhered to. I hereby consent to the research results being published in the medical literature as long as patient confidentiality is protected. I am aware that I may refuse to participate in such a study and that this refusal will not adversely affect my treatment in any way.

APPROVAL

I have read the above information and have been informed by the physician who has signed below. I was informed about the purpose, reasons and benefits, risks, complications, alternatives and additional treatment interventions of the treatment/procedure to be performed. I approve this transaction consciously, without needing any further explanation, without any pressure. (**Hand written "I READ, UNDERSTAND, RECEIVED A COPY")**

……..

Patient Name-Surname (**hand written)**	**Signature**	**Date/Time Consent Received**
……..…..……		……./……/……... …….

IF THE PATIENT CANNOT CONSENT:

Patient / legal representative Name-Surname (**hand written**)	**Signature**	**Date/Time Consent Received**
……..		……./……/……... …….

REASON FOR THE PATIENT'S FAILURE TO CONSENT (TO BE FILLED IN BY THE PHYSICIAN):

I will inform the patient/legal representative whose name is written above about the disease, the treatment/procedure to be performed, the purpose, reason and benefits of this treatment/procedure, the care required after the treatment/procedure, the risks and complications of the treatment/procedure, the alternatives of the treatment/procedure, if necessary for the treatment/procedure. If necessary, adequate and satisfactory explanations have been made about the type of anesthesia to be applied and the risks and complications of anesthesia. The patient/legal representative has signed and approved this form with his/her own consent, stating that he/she has been adequately informed about the treatment/procedure.

PHYSICIAN WHO WILL APPLY THE TREATMENT/PROCEDURE	**Signature**	**Date / Time**
Name and Surname:..……..…		...../...../..... .....:....
Title :…….		

IF THE PATIENT HAS A LANGUAGE / COMMUNICATION PROBLEM;

I translated the explanations made by the doctor to the patient. In my opinion, the information I translated was understood by the patient.

Translator's	**Signature**	**Date / Time**
Name and Surname (**hand written**):		... .../...../..... .....:.....

EXPLANATION:

• You can apply to the **Patient Rights Unit** during the day for all your complaints about medical practices or any issue you want to address.

• Legal Representative: Guardian for those under guardianship, parents for minors, and first degree legal heirs in cases where these are not available. Signing this consent document does not eliminate the patient's legal rights.