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:

In case of missing teeth, the place of dental implants in treatment plans is increasing. Alveolar ridge deficiencies are the most challenging situations in implant surgery. Alveolar ridge deficiencies in the horizontal or vertical direction may make implant placement impossible. In addition, the spongy structure of the upper jaw compared to the lower jaw makes implant surgery more difficult.
• CRET SPLIT TECHNIQUE is a technique used effectively to increase the alveolar bone volume, especially in the buccolingual direction, and is applied according to the principle of expanding the bone segments after osteotomy performed in the horizontal direction in the alveolar bone.
• CRET SPLIT OSTEOTOMY; Following local anesthesia, it is the procedure of performing a horizontal (longitudinal) incision in the bone in order to increase the width of the bone by increasing the buccolingual width of the Aveolar ridge.

EXPECTED BENEFITS FROM THE PROCESS:
• Increasing the buccolingual width of the alveolar crest.

CONSEQUENCES THAT MAY BE ENCOUNTERED IF THE PROCEDURE IS NOT IMPLEMENTED:
• Lack of sufficient bone volume (buccolingual) for implant application.

ALTERNATIVES TO THE PROCEDURE, IF ANY:
• Bone graft application procedures and prosthetic planning vary.

RISKS AND COMPLICATIONS OF THE PROCEDURE:

• During planned treatments and procedures, local anesthesia-related or routine surgical complications may develop.
• If you have a previous history of allergy to local anesthesia, heart disease, blood diseases, high blood pressure or other general health-related conditions, be sure to warn your physician. Your doctor is not responsible for any problems that may occur due to misrepresentation.
• Pain, swelling, burning, infection, and unexpected allergic reactions may develop during and after local anesthesia application. Allergic reactions; Itching, rash, nausea, vomiting, difficulty breathing, increase (tachycardia) or decrease (bradycardia) in heart rate, may be life-threatening with a very low probability.

• Another risk is regional anesthesia (during local anesthesia), temporary or permanent nerve damage, and numbness of the facial nerve, which moves facial muscles such as the eyelids and forehead. This is a condition that goes away on its own within an hour or two.
• As with surgical procedures, there may be swelling, discomfort and limitation in opening the mouth after the surgery, lasting for 2-3 days or more.
• The bone wall may break during the procedure,
• During the healing process, the stitches may open and infection may occur.
• 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.
• Injuries may occur to the nerves that control facial muscles. This situation 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.

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:
• If local anesthesia will be applied to provide pain control during the treatments, if necessary, the gums or the inner part of the cheek will first be anesthetized with a topical anesthetic substance (spray). When the area is numb, anesthetic liquid is injected with a syringe and the tooth and the area where it is located are numbed for a while. After local anesthesia, although rare, the patient may experience allergic reactions, loss of sensation, bleeding, temporary muscle spasms, and temporary facial paralysis.
• Local anesthesia is a successful application as long as there are no anatomical differences or acute infections in the area. When local anesthetic substances are applied to the area to be treated, they temporarily stop nerve conduction and provide numbness **for 1-4 hours**, depending on the amount of the substance applied and the place of application. For this reason, eating and drinking is not recommended until the numbness subsides to prevent wounds on the inside of the cheek and lips due to biting.
• In case of bleeding during the application, various haemostatic drugs (Transamine amp and K vit.amp. etc.), various haemostatic medical materials, anti-inflammatory agents, graft-membrane material, periodontal pastes can be used when necessary. 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. The medications your doctor recommends you use will have some side effects. These side effects include nausea, vomiting, weakness and drowsiness, and anaphylactoid reactions.

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.
• Avoid sudden movements (moving the head, intervening with hands) while performing the procedure inside the mouth. Failure to pay attention may cause injuries to the surrounding tissue and adjacent teeth.
• Before giving an anesthetic agent, your doctor should be informed about any systemic disease, pregnancy, any medications used, or any allergic condition. Excessive use of alcohol and cigarettes weakens the effect of anesthesia. It then hinders the healing process.
• The rate of lung infection (microbial diseases), thrombosis, heart and lung complications (adverse situation) is higher in smokers. Quitting smoking 6 weeks before the procedure may help reduce the risk.
• The patient should bite the tampon placed in the procedure area for 30 minutes.
• It is normal to have bleeding in the form of leakage, swelling, and bruising in the face and neck area on the first day after removing the tampon. During this process, the patient should not rinse his mouth, spit, drink fruit juice through a straw, etc. products should not be consumed.
• One should stay away from activities that require heavy effort and, if necessary, sleep in a semi-sitting position at night.
• Ice can be applied to the procedure area externally.
• Hot and grainy foods should be consumed for the period specified by the physician.
• Care should be taken to clean the wound area.
• Stitches should be removed within the time specified by the physician.

• If there is pain in the procedure area that does not go away or becomes increasingly severe, consult your physician immediately.

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 application, the tampon should be removed according to your doctor's recommendation, the tampon should be changed frequently, it should not be spit out, if blood occurs, it should be swallowed, the procedure site should not be opened or tampered with.
• 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 **Signature** **Date/Time Consent Received**

Name-Surname (**hand written)**

……..…..…… ……/……/……... …….

IF THE PATIENT CANNOT CONSENT:

Patient / legal representative **Signature** **Date/Time Consent Received**

Name-Surname (**hand written**)

…….. ……/……/……... ……

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.