ANKARA CHAMBER OF DENTISTS
PATIENT CONSENT FORM

			Date			
Patient's Surname, Name		**Protocol No**				

Dear Patient/Patient's Relative

It is your utmost natural right to know about your illness and recommended procedures and therapies for the diagnosis and therapy of your illness. After getting informed about the benefits and possible risks of the medical treatment; whether or not to consent with the process to be performed is subject to your own decision. If you wish, all the data and documents concerning your oral health can be given either to you or to one of your relatives to be nominated by you. You may refuse to be informed except for cases that require legal and medical obligations. You may revoke your consent at any time you wish. This situation will not affect your future therapies under any circumstances whatsoever. However, your right to do so is contingent on the condition that "there is no medical inconveniency ". When this situation exists, a statement for the Revoke of Informed Consent shall be issued and attached to this form.

- I the undersigned or the legal guardian has been informed by the dentist …………………about the condition of my oral health.
- Concerning the diagnosis/therapy of my illness ………………. I am informed about the implementation of ………………………….
- Probable unwanted side effects and possible risks are explained in detail.
- Issues needed to be cared for before and after the treatment are explained.
- When refuse this diagnostic/therapeutic process; I am informed about the risks that might affect my health and whether or not there are any other diagnostic/therapeutic procedures that might be implemented in lieu of this diagnostic/therapeutic process.
- Necessary details regarding the possible costs of this diagnostic/therapeutic process are explained to me.
- I am told that the dentist, if necessary, may acquire consultation from other medical doctors during the diagnostic/therapeutic process and that another medical doctor may participate in this diagnostic/therapeutic process.
- I hereby consent the application of …………………. treatment on myself/on the patient I am representing by and under the authority, supervision and methodology of the dentist ….…………………….'s at ……………. Clinic.

( ) Verbal information is provided.

( ) Read the informative booklet, understood and accepted the content.

( ) I hereby allow that my photographs at the clinic can be taken for training, diagnosis, follow-up and for scientific purposes by keeping my identity details secret and can be used for scientific, training and research purposes together with clinical findings .

This is to certify that I have fully understood and answered the questions asked to me by Dentist ………………. as well as the issues noted in the information form and accept the treatment to be applied to me by my dentist under the light of the information explained.

NOTE: ……
……..

	Name, Last Name	**Signature**
Patient/Legal Representative*		
Witness		
Translator		
Healthcare Personnel in Charge		