Association between the Irrigation-Agitation Techniques and Periapical Healing of Large Periapical

Lesions: A Randomized Controlled Trial

Clinical Trial Number: NCT06204887

Date: 16.05.2024

General Consent Form

The undersigned I/patient's guardian
…….,

I was informed about the diagnosis and treatment planning made by Dentist …....., alternative treatments, results, undesirable side effects, I understood. I accepted the treatment to be applied.

It was explained, I understood and accepted that the planning could change with new situations that may arise during/during the treatment.

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

All my questions about my treatment or the treatment of my guardian were answered. It was explained, understood and accepted that the success of the treatments also depended on me, that I should follow the recommendations and oral hygiene at home, that I should follow the recommendations regarding harmful habits that should be abandoned, and that the drugs in the prescriptions to be written should be used at doses and times in accordance with the recipe.

I was told, understood and accepted that the treatments to be applied aim to protect oral and dental health, that medical services will be carried out diligently, but that the result cannot be guaranteed in medical procedures.

As stated above, I have approved and accepted the dental treatments that were explained to me/her guardian during 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 consent to the use of radiographs, photographs, videos and other documents belonging to me / my guardian as anonymized data in studies for educational and / or scientific purposes. I …..(Write "I allow" or "I do not allow" in your handwriting) my personal data to be shared with third parties and institutions, including public institutions and organizations.

…..(Write "I understand what I have read, I accept" in your handwriting.)
Date:……

Patient Name-Surname:…….

Legal Representative of the Patient (* – Degree of Relation) Name-Surname: ……

T.R. Identity Number : …….

Address: ……..

Telephone: ……

Signature: …….

Physician's Name-Surname: ……

History: …….

Signature: …….

* Legal Representative: Guardian for those under guardianship, parents for minors, 1st degree legal heirs in the absence of them. (Please indicate the degree of closeness next to the name of the patient's relative.)

CHANGES IN THE TREATMENT PLAN

The following changes were made in the treatment plan made on ……/…/……..

Tooth	**Diagnosis**

My dentist explained why treatment change is needed, the risks involved, possible problems, alternative methods, changes that may occur after treatment, the possibility of success and events that may occur during the healing process.

I accept the change in the treatment plan mentioned above…..... (Please write "I accept" or "I do not accept" in your handwriting.)

Name-

Surname **Signature**
Date/Time

Patient / Patient's Legal Representative (*)
-the degree of proximity

Physician making the information

Translator (if used)

* Legal Representative: The guardian for the wills, the parents for the minors, the 1st degree legal heirs in the absence of them. (Please indicate the degree of closeness next to the name of the patient's relative)