



HD.RB.38 | YT:14.01.2015 | REV.NO:01 | REV.T: 18.04.2022

Dear patient/parent/guardian,

- Please read this document carefully.
- It is your natural right to be informed about your medical condition and the treatments and procedures recommended for the treatment of your disease.
- The purpose of these explanations is to inform you about issues related to your oral and dental health and to ensure your participation in the treatment process.
- If you have questions other than those mentioned here, it is our duty to answer them. We are here to help you.
- It is up to your decision to approve the procedure after learning the benefits and possible risks of diagnostic interventions, medical and surgical treatments.
- If you wish, all information and documents regarding your health can be given to you or a relative you deem appropriate.
- If you have reading and writing problems, or if you want another person you designate to participate in the process of authorizing the transactions to be performed on you, you can allow the person you designate as a witness to participate.
- You can refuse to be informed except in cases of legal and medical necessity.
- You have the right to withdraw your consent at any time. This will not disrupt your future treatment in any way. However, from a legal perspective, this right is subject to the condition that "there is no medical problem". When this happens, an Informed Consent Withdrawal Report will be prepared and attached to the back of this document.
- You must inform your physician about current systemic diseases, allergies, medications used and general health status. You are responsible for hiding or not disclosing any matter.
- In order not to disrupt the order and treatment program of our health institution, be careful to stick to your appointments and arrive on time. If you are not able to come, please cancel your appointment at least 24 hours in advance. If you do not arrive at your appointment time, your appointment may be postponed to another day depending on the clinic's busyness.
- Information and consent processes will be carried out with you for patients who are unconscious, pediatric patients, mentally disabled patients, who do not have the ability to make decisions regarding diagnosis and treatment, and patients who require urgent intervention, for whom you are the parent or guardian.
- The process of informing and obtaining consent of the disabled people of whom you are a parent or guardian, in accordance with their disability status, will be carried out with you.
- If necessary, you can reach the clinic where you received treatment/procedures during office hours (8.30-16.30) by calling 0246 211 33 49 for medical assistance.

**1. INFORMATION**

By applying a whitening agent to teeth that have changed their normal color for any reason, the patient's aesthetic expectations are tried to be met by making the teeth whiter and normal. For these transactions, which are not included in the Health Practice Communiqué (HPC), charges are made according to the Public Health Services Sales Tariff Price List.

THE TOOTH TO BE TREATED	DIAGNOSIS	TREATMENT PLANNING
55 54 53 52 51   61 62 63 64 65 18 17 16 15 14 13 12 11   21 22 23 24 25 26 27 28 48 47 46 45 44 43 42 41   31 32 33 34 35 36 37 38 85 84 83 82 81   71 72 73 74 75		

**Content of Treatment:**

**Vital Whitening:** By applying a whitening agent to the teeth that have changed their normal color for any reason, the patient's aesthetic expectations are tried to be met by making the teeth become whiter and normal color. The whitening agent used in this treatment can be applied in the clinic with a special whitening device or at home by applying it into a transparent plate.

Expected benefits from the procedure: The teeth will become whiter or their normal color. **The consequences that may be encountered if the procedure is not applied:** The teeth remain in their old and dark colors. **Alternative to the procedure:** There is no alternative to the vital whitening treatment. **Complications of the procedure:** If the discoloration of the tooth is very severe, a very late or no response may be received to the treatment. In cases of discoloration such as fluorosis, a matte whiteness can be achieved on the teeth. During treatment, the patient; As a result of sensitivity complaints and contact of the whitening agent with soft tissues, pain, tenderness, burning, and temporary discoloration may occur in the tissues. Allergic reactions may occur depending on the whitening agents used. **Estimated duration of the procedure:** 60 minutes. **Things to consider before and after the procedure and problems that may occur if care is not taken:** Providing oral care before the procedure is important for the success of the treatment. Sensitivity complaints may continue for a short time after treatment. The patient should pay attention to the recommendations of his physician and pay attention to oral care. Foods and drinks that may stain and discolor teeth, such as tea and coffee, should be avoided. If these issues are not taken into consideration, the teeth can easily become discolored and return to their previous state.

**Content of Treatment:**

**Devital whitening:** It is applied to teeth that have undergone root canal treatment and changed their color, have abnormal color that has undergone root canal treatment for any reason, or teeth that do not aesthetically satisfy the patient. With the help of a low-speed handpiece or a water-cooled high-speed handpiece, some of the filling in the tooth is removed and a whitening agent is placed in the prepared slot, and this agent is renewed every 3-7 days, and the sessions continue until the desired color is achieved. During the treatment, the patient is given a temporary filling. When the treatment is completed, the teeth are permanently restored. **Expected benefits from the procedure:** The teeth will become whiter and normal in color. **The consequences that may be encountered if the procedure is not applied:** The teeth remain in their old



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and dark colors. **Alternative to the procedure:** There is no alternative to devital whitening treatment. **Complications of the procedure:** If the discoloration of the tooth is very severe, a very late or no response may be received to the treatment. Conditions such as cervical resorption (loss of tooth structure in the neck part) may occur in the treated teeth. In this case, the dentist may apply the necessary treatment to the tooth or the tooth may be extracted. **Estimated duration of the procedure:** 40 minutes. **Things to consider before and after the procedure and problems that may occur if care is not taken:** Providing oral care before the procedure is important for the success of the treatment. Teeth are permanently restored 10-15 days after the treatment is completed. Hard foods and drinks such as tea and coffee, which may stain and discolor the teeth or damage them, should be avoided. The patient should pay attention to oral care and follow the recommendations of dentist. If these issues are not taken into consideration, the teeth can easily become discolored and return to their previous state, or if damaged, they can be pulled out.

Date:

The dentist responsible for the patient

Name-Surname:

Signature:

The assistant professor responsible for the patient

Name-Surname:

Signature:

**2. CONSENT (PERMISSION, CONSENT)**

I/the undersigned guardian of the patient .....

Dentist..... I have been informed about the diagnosis and treatment planning, alternative treatments, results, unwanted side effects, I have been informed about, understood and accepted the treatment to be applied. I have been informed about the possible risks that may arise if the treatment is not applied, cost calculations according to alternative treatments, consultation from other physicians may be requested if deemed necessary, I have been informed about, understood and accepted. I was informed that treatment services are provided by appointment in the clinic of the Department of Pedodontics for patients other than emergencies (fractures and injuries in the mouth, teeth, jaw area, facial swelling), patients requiring special care (disabled), patients with life-threatening systemic diseases, as determined by the first examination physician. All questions I wondered about the treatment of my treatment/guardian were answered. It was explained to me that attending the appointments without fail and following the recommendations and practices of the physician regarding the treatment can directly affect the results of the treatment. I was explained, understood and accepted that the success of the treatments to be performed depends on me, that I should follow the oral cleaning and recommendations at home, that I should fulfill the recommendations regarding harmful habits that should be abandoned, and that I should use the medications in the prescriptions to be prescribed in the doses and durations appropriate to the recipe. I was explained, understood and accepted that the treatments to be applied aim to protect oral and dental health, that medical services will be carried out with care, but that the result cannot be guaranteed in medical procedures. I was informed in detail about patient rights and responsibilities, physician rights and obligations. I am aware that Süleyman Demirel University Faculty of Dentistry is an educational institution and that trainee dentists and specialty students work here. I give permission to Süleyman Demirel University Faculty of Dentistry faculty members, dentists and trainee dentists to perform oral dental examination, diagnosis and treatment of the individual whose parent/guardian I am. I ..... (Write "I give" or "I do not give" in your handwriting.) permission to take photographs and use my medical records during the intervention/treatment to be applied to me, provided that the identity information is kept confidential and used only for education and research purposes.

**(\*) Legal Representative:** For minors and/or incompetent persons, the informed consent of the parent or guardian is required.

Dear Patient, You have the right to be informed about your health condition and the benefits/harms, risks and alternatives of the proposed diagnostic or therapeutic procedures; to accept or partially/completely reject the treatment; and to stop the procedures at any stage! This document, which we want you to read and understand, has been prepared not to scare you or to keep you away from medical practices, but to inform you, to determine whether you consent to these practices and to obtain your consent. This consent form consists of 2 pages and has been prepared in 2 copies in accordance with Article 70 of the Law No. 1219 and Article 26 of the Turkish Criminal Law (No. 5237), and one copy has been given to the patient/patient's legal representative.

THE TREATMENT FOR MY DISEASE HAS BEEN EXPLAINED TO ME AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT. (Note: This statement will be printed below in the patient's/relative's OWN HANDWRITING).

.....  
 PATIENT'S/RELATIVE'S/GUARDIAN'S  
 NAME SURNAME :.....  
 DATE:.....  
 TIME:.....  
 SIGNATURE

.....  
 THE PHYSICIAN PROVIDING THE INFORMATION  
 NAME SURNAME :.....  
 DATE:.....  
 TIME:.....  
 SIGNATURE/STAMP