



HD.RB.43 | YT:14.01.2015 | REV.NO:01 | REV.T: 18.04.2022 | S.NO: 1/2

**File number:**

BARCODE

**Patient Name and Surname:**

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.
- To get medical help when necessary, you can call 0246 211 33 49 during working hours (8.30-16.30) to reach the clinic where you received your treatment/procedure.

**1- INFORMATION**

THE TOOTH TO BE TREATMENT	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		

Primary teeth can be extracted and lost early for various reasons such as caries, trauma or systemic disease. It is important to preserve the location of permanent teeth so that your child will have a proper set of teeth in the future; A space maintainer must be made to protect this place. The extraction spaces must be protected in case the teeth adjacent to the extracted primary tooth slide/displace into the extraction space and the tooth in the opposite jaw may erupt further. This protection is provided by two types of methods: fixed (a crown/band/wire/fiber material that is temporarily bonded to adjacent teeth and removed when the permanent tooth comes into the mouth) or removable (a simple prosthesis that can be attached and removed). It is prepared as fixed or removable, depending on the child's dental development and the number of missing teeth. It should remain in the mouth until the permanent tooth underneath the extracted primary tooth erupts into the mouth. For space maintainers prepared by dental technicians, the technician's fee is covered by the patient. For procedures not included in the medical enforcement declaration list, charges are made according to the Public Health Services Sales Tariff Fee List.

**Content of the treatment:**

**X-ray:** It may be necessary to take an x-ray from the mouth and/or jaw and face area at the beginning of the treatment, during the treatment and after the treatment for control purposes. The application is performed by intern students under the supervision of an x-ray technician, research assistant, faculty member and/or research assistant in an x-ray room configured in accordance with the legislation. Your physician determines the number of x-ray examinations to be requested. Protective equipment (lead apron, neck collar) is worn before the x-ray. There are different types of x-rays obtained by placing the x-ray film inside the mouth, holding it manually by the patient's guardian or himself (periapical, occlusal radiography), biting it between the teeth by the patient (bitewing radiography), or by rotating an x-ray device around the patient's head (panoramic).

**Expected benefits of the procedure:** It enables the visualization of fractures and decay areas that cannot be noticed during visual examination (for example, cavities between teeth) and cavities developing under existing fillings. It indicates abnormalities related to teeth. It provides information about bone loss caused by gum disease. It allows visualization of problems in the root canal. It is helpful in identifying pathologies such as cysts and tumors in bone and soft tissue. It ensures that the diagnosis is made, the treatment to be applied is planned correctly, and the treatments applied are controlled. It provides information about the development and growth of children's mouth-tooth-jaw. **Consequences that may be encountered if the procedure is not applied:** If it is not applied, diagnosis may be difficult, diagnosis may be delayed, application of the correct treatment may be difficult and delayed, and the success of the applied treatment cannot be evaluated. **Alternative to the procedure:** None.

**Complications of the procedure:** The X-ray used in X-ray shooting is harmful to living tissues. For this reason, your doctor will request the minimum number and type of x-rays required for you. Nausea and sometimes vomiting may occur during x-rays. In this case, precautions such as rinsing the mouth with cold water and applying local anesthetic spray can be taken. It is necessary to remain still during the procedure. If the film is moved or the film is shifted, the film may turn out bad and be reshot.

**Estimated duration of the procedure:** 2-10 minutes. **Points to be taken into consideration before and after the procedure and problems that may occur if care is not taken:** In necessary cases (child patients, pregnancy and illness cases), lead apron and neck collar should be used. If not used in specified situations, harmful effects of X-ray may occur. Before taking an x-ray showing all teeth, the patient should remove all metal items (earrings, buckles, necklaces, glasses, hearing aids, etc.) from the head and neck area. If these items are not removed, the x-ray image may be distorted. During x-rays, you should remain motionless to avoid repeating x-rays. **Space maintainer application:** After the wound in the tooth extraction area has healed, in the first session, the patient is measured and an intraoral model is obtained. In case of single tooth loss, a fixed space maintainer (can be active) is planned to prevent the teeth adjacent to the extracted primary tooth from shifting/displacing towards the extraction space; A removable space maintainer is planned to prevent the teeth adjacent to the extracted teeth from shifting/displacing into the extraction space as a result of 2 or more tooth extractions. The space maintainer planned on the model is prepared by the dentist or dental technicians. In the second session, the prepared space maintainer is glued to the tooth if it is a fixed space maintainer and its use is demonstrated practically if it is a removable space maintainer.

**Expected benefits from the procedure:** With the application of space maintainer, the possibility of the teeth adjacent to the extracted primary tooth shifting/displacing towards the extraction space and the tooth in the opposite jaw being elongated is eliminated. By preserving this space until the permanent tooth erupts into the mouth, the permanent tooth is ensured to erupt in the ideal position and at the right time. Orthodontic problems that may occur in the future are prevented or alleviated. It eliminates the negative effects (psychologically) that loss of front teeth may have on the child. **Consequences that may be encountered if the procedure is not applied:** If a space maintainer is not made after premature loss of primary tooth, the adjacent teeth will shift and cover the place of the lost primary tooth, the tooth in the opposite jaw of the gap will grow and the permanent tooth may or may not erupt out of its normal place, causing orthodontic problems. **Alternative to the procedure:** There is no



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alternative to space maintainer treatment. Orthodontic treatment can be considered as the furthest alternative. **Complications of the procedure:** During impression; Stimulation of the gag reflex, nausea, vomiting, sensitivity-allergy to the impression material may develop. If the child's compliance with the physician is disrupted during the application of a fixed space maintainer, the crown/band/wire/fiber material may be swallowed or leak into the trachea, or may not be adhered properly and may fall or break in a short time. When using fixed space maintainers / removable space maintainers; Sensitivity to the crown/band/wire/fiber material/bonding material/acrylic used - development of allergy, loosening of the crown/band/wire/fiber material or bonding material, falling, swallowing, escaping into the respiratory tract, crown/band/wire/fiber material or Displacement of teeth as a result of not applying to the clinic on time due to reasons such as falling of the bonding material / loss of the space maintainer / not being used, causing food accumulation on the tooth to which the fixed space maintainer crown/band/wire/fiber material is bonded or on the teeth adjacent to the removable space maintainer due to inadequate oral and dental care, and Situations such as the development of caries, deterioration of the compatibility of the prosthesis due to improper or regular use of the removable space maintainer, requiring renewal or repair, and injury in the mouth due to the improper or regular use of the removable space maintainer may be encountered. If oral care is not taken into consideration while using space maintainers, gingival infections may occur. **Estimated duration of the procedure:** 40 minutes. **Points to be taken into consideration before and after the procedure and problems that may occur if care is not taken:** During the procedure, you must stand still and follow the doctor's instructions. Otherwise, the impression process may not be done properly and problems may occur in the compatibility of the prostheses; the fixed space maintainer may not be adhered properly and may fall off in a short time. It is important not to consume sticky and/or hard foods such as chewing gum and caramel. After meals and when necessary, teeth and space maintainers should be cleaned as directed by the physician. Attention should be paid to oral care. If oral care is not taken into consideration while using space maintainers, food accumulation on the teeth, caries development and gingival infections may occur. The space maintainer should not be pressed or played with the tongue or fingers, the child should not sleep with the removable space maintainer, and when removed from the mouth, it should be kept in a container filled with water. The child must be encouraged to use the space maintainer. The doctor's recommendations regarding space maintainers should be followed and regular check-ups should be performed. In case of breakage, dislocation or compatibility problems in space maintainers, a physician should be consulted as soon as possible. In these cases, space maintainers may need to be changed and renewed in line with growth and development and as needed.

Date:  
The physician responsible for the patient  
Name and surname:  
Signature:  
The faculty member responsible for the patient  
Name and surname:  
Signature:

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

I am the undersigned/the patient's guardian.....  
I was informed and understood about the diagnosis and treatment planning made by Dentist....., alternative treatments, results and undesirable side effects. I accepted the treatment to be applied.  
It was explained to me that the planning may change due to new situations that may arise during/during the treatment period, I understood and accepted it. I was informed, understood and accepted the possible risks that may arise if the treatment is not applied, cost calculations according to alternative applications of the treatment, and the possibility of requesting consultation from other physicians if deemed necessary.  
Treatment services are provided by appointment at the Department of Pedodontics clinic for patients other than emergencies determined by the first examination physician (fractures and injuries in the mouth, teeth, jaw area, facial swelling), patients requiring special care (disabled), patients with life- threatening systemic diseases. I was informed about it.  
All the questions I had about my treatment/treatment of the person I am guardian of were answered. It was explained to me that attending the appointments without interruption and following the doctor's recommendations and practices regarding treatment can directly affect the results of the treatment. I was explained, understood and accepted that the success of the treatments depended on me, that I should follow the oral hygiene and recommendations at home, that I should follow the recommendations regarding harmful habits that should be given up, and that I should use the medications in the prescriptions in doses and durations appropriate to the prescription.  
I was informed, 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 results of medical procedures cannot be guaranteed. I was informed in detail about patient rights and responsibilities and physician rights and obligations.  
I was informed about the enforcement declaration published by the Social Security Institution (SGK) regarding the relevant treatments. I have been informed that the invoices for the items that SSI does not pay for the materials to be used during the stages of the treatment must be paid by me.  
I know that Süleyman Demirel University Faculty of Dentistry is an educational institution and intern physicians and specialist students work here. I allow Süleyman Demirel University Faculty of Dentistry faculty members, dentists and intern dentists to perform oral and dental examination, diagnosis and treatment of the individual of whom I am the parent/guardian. I.....photographs to be taken and my medical records to be used during the intervention/treatment to be applied to me, on the condition that my identity information is kept confidential and used only for education and research purposes. (Please write "I allow" or "I do not allow" in your handwriting.)  
(\* **Legal Representative:** Informed consent of the parent or guardian is required for persons who are minors and/or incompetent.  
Dear Patient, To have information about your health condition and the benefits/harms, risks and alternatives of the procedures for the diagnosis or treatment recommended for you; accept or partially/completely reject treatment; You have the right to stop the transactions 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, determine whether you consent to these practices, and obtain your consent. This consent form consists of 3 pages and was prepared in 2 copies in accordance with Article 70 of Law No. 1219 and Article 26 of the Turkish Penal Code No. 5237, one copy of which was given to the patient/legal representative of the patient.

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