ISTANBUL CHAMBER OF DENTISTS

GENERAL INFORMATION

Dear .....,

This form has been prepared to inform you and to obtain your consent before starting your treatment. Please read it carefully, fill in the required sections, and sign at the end.
If there is anything unclear, do not hesitate to ask; we will be happy to explain.
Thank you for your time and cooperation.

You must inform your dentist about any systemic diseases, medications you are currently taking, and your overall health condition.
You are responsible for any consequences arising from withholding or failing to declare such information.

During your visit to our clinic, it is your natural right to be informed about the examinations, evaluations, tests, procedures, and their costs that will be performed before dental treatment.
This will allow you or your legal guardian to understand the planned treatments.
The purpose of these explanations is to ensure that you are fully informed and involved in the treatment process for improving and maintaining your oral and dental health.

Once you have been informed of the benefits, possible risks, and costs of the treatment or procedures, your consent will be required before proceeding.

Please attend your appointments on time to avoid disrupting the clinic’s schedule and treatment program.
If you are unable to come, please cancel at least 24 hours in advance.

We wish you a healthy and happy life.

IMPORTANT NOTE

Although your dentist treats only conditions related to your mouth and jaw, please remember that these regions are an integral part of your body.
Your general health problems and any medications you have used or are currently using may significantly affect your dental treatment.
Therefore, please answer all the following questions accurately and completely.

MEDICAL HISTORY

Do you have any of the following conditions?

- Heart disease ……
- Hypertension ……
- Diabetes ……
- Liver disease ……
- Hepatitis A/B/C ……
- Bleeding problems ……
- Blood disorders ……
- Lung diseases ……
- Chemotherapy ……

Rheumatic diseases ……

-
-

Radiotherapy ……

-
-

Stomach disorders ……

-
-

Asthma ……

-
-

Intestinal disorders ……

-
-

Sinus problems ……

-
-

Kidney disease ……

-
-

Thyroid disease ……

-
-

Psychological disorders ……

-
-

AIDS ……

-
-

Herbal medicines/supplements ……

•

Are you currently under a doctor’s supervision for any illness?
……
……

Have you ever been hospitalized or undergone surgery for any illness?
……
……

Are you currently taking any medications? Please specify their names, purposes, and duration of use:
.....

Do you smoke? If yes, how much?
……

Are you pregnant?
……

Do you have any allergies?
……

Have you ever received local anesthesia before?
……

Have you ever taken or are you currently taking any medication that affects bone tissue?
……

Do you have any other condition not mentioned above for which you are or have been treated?
……

GENERAL TREATMENT PLAN

.....

GENERAL CONSENT FORM

I, the undersigned (or the patient’s legal guardian)
.....

have been informed by Dr. .....
about the diagnosis, treatment plan, alternative treatments, possible outcomes, and

unwanted side effects.
I have understood and accepted the proposed treatment.

I have been informed that during the course of treatment, new conditions may arise requiring modifications to the plan. I understand and accept this.

I have been informed and accept the possible risks if treatment is not performed, alternative cost calculations, and that consultations with other physicians may be requested when necessary.

All my questions regarding my treatment (or that of the person I represent) have been answered.
I understand that the success of the treatment also depends on me: maintaining good oral hygiene, following recommendations, avoiding harmful habits, and using prescribed medications in proper doses and durations.

I have been informed that dental treatments are performed to protect oral health and that while medical services will be provided with due care, the results cannot be guaranteed.
I understand and accept this.

I have approved and accepted the dental treatments described and agreed upon during treatment planning.

I have been informed in detail about patient rights and responsibilities, as well as the rights and obligations of the dentist.

I give my consent for radiographs, photographs, videos, and other documents belonging to me/the patient to be used as anonymized data in educational or scientific studies.
I ..... (“give” / “do not give”) permission for my personal data to be shared with third parties and institutions, including public authorities.

Please write in your own handwriting:
“I have read, understood, and accept.”

Date: .....
Patient’s Full Name: .....
ID No.: .....

*Legal Representative (- Relationship):**
Name-Surname: .....
ID No.: .....
Address: .....
Phone: .....
Signature: .....

Interpreter (if applicable):
Name-Surname: .....
Signature: .....

Dentist:
Name-Surname: .....
Date: .....
Signature: .....

*Legal Representative: Guardian for those under guardianship, parent for minors, or if unavailable, the first-degree legal heir. (Please indicate degree of relationship.)

CHANGES IN TREATMENT PLAN

On …… date, the following changes were made to the treatment plan:

TOOTH DIAGNOSIS PLANNED TREATMENT

My dentist has explained the reasons for the changes, the associated risks, potential problems, alternative options, possible outcomes, success rate, and healing process.

I ..... (“accept” / “do not accept”) the above changes to the treatment plan.

Name–Surname / Signature / Date–Time
Patient / Legal Representative (* Relationship)

Explaining Dentist: .....
Interpreter (if applicable): .....

Each page must be signed separately.