I. TO INFORM

Every orthodontic treatment has its limits and possible risks. These should be taken into consideration when deciding whether to undergo orthodontic treatment. Therefore, please read the information below and get information from your doctor on any issues you do not understand.

Even if orthodontic treatment is carried out in a planned manner and in accordance with the rules, it cannot be guaranteed that all expected results will be achieved. Because there are always situations such as the limits of the chosen treatment and some factors specific to the patient (for example, genetic structure, unpredictable growth and development after treatment, the response of oral and dental tissues to orthodontic treatment, etc.).

Allergies: Patients may be allergic to some of the materials used in orthodontic treatment. In this case, it may be necessary to change the treatment plan or stop the treatment.

Orthodontic Devices: It may be necessary to use extraoral devices (devices such as neck collar/face mask) or intraoral/extraoral rubber rings that must be put on and removed by the patient. The treatment of patients who do not use these devices as recommended by the doctor is terminated by the decision of the relevant faculty member after 3 verbal and 2 written warnings.

Tooth Extraction: In some cases, permanent teeth may need to be extracted to treat the orthodontic problem, and this is a routine practice. In this method, called Extraction Orthodontic Treatment, the teeth that your doctor deems medically appropriate are extracted.

Tooth and Gum Health: Teeth that are not brushed adequately during treatment may develop caries, inflammation of the gums, gingival recession and supporting (alveolar) bone loss. The patient is responsible for any negativities that may occur due to inadequate oral hygiene during the treatment. Treatment of patients with poor oral hygiene despite warnings is terminated by the decision of the relevant faculty instructor.

Root Length Shortening (Root Resorption): During orthodontic treatment, the roots of some teeth may shorten. This situation is known as root resorption and is a unique condition that cannot be predicted or prevented. When severe root length shortening is detected, the physician may stop orthodontic treatment.

Temporary Anchorage Devices: Treatment may require temporary support devices such as metal screws and plates anchored to the bone. These devices also have some risks. There is a possibility that the tissue around the screws or plates may become inflamed. The tooth root or nerve may be damaged when these devices are placed.

Treatment Duration: The time required to complete the treatment may be longer than expected. Patients cannot miss their appointments for any reason and must attend their appointments regularly. If appointments are not adhered to, a warning letter will be given to the patient and/or their legal representative at most 2 times. If the problems continue, the treatment of the patients will be terminated by the relevant faculty member.

Retention Devices: To maintain the improvement achieved after orthodontic treatment, the patient must be fitted with removable appliances or wires fixed to their teeth. In patients who do not use these appliances as

recommended, the patient is responsible for the deterioration in the tooth and jaw relations. Post-treatment deteriorations are situations that are not the responsibility of the orthodontist and may develop beyond his control.

Surgical Treatments: In cases where surgical treatment is decided and the patient approves this option, the patient's treatment is terminated if the patient gives up the surgery voluntarily in the future.

Impacted Teeth: If there is not enough space in the jaw arch for the tooth to erupt, the tooth remains impacted. In such cases, the impacted tooth can be maintained or extracted.

Orthodontic Traction to Impacted Tooth: Space must be made so that the impacted tooth can be continued into the mouth and placed in the jaw arch. To gain space, any one or more of the permanent teeth in the mouth must be extracted. However, in cases such as the curvature of the root tip of the impacted teeth or the fusion of the tooth root with the bone (ankylosis), the tooth may not be able to move within the bone and may not be in the dental arch. This situation is unpredictable, unpredictable, and undetectable by the dentist. The impacted tooth may not be able to settle into its place in the jaw arch despite all the applications and tooth extractions.

Extraction of Impacted Teeth: These teeth can be extracted due to the difficulty in maintaining impacted teeth or in line with the patient's request. The patient should obtain information about the risks and complications from the surgeon or dentist who will perform this procedure.

II. CONSENT

Your orthodontic problem and treatment plan, which we determined as a result of clinical and radiological evaluations, are listed below.

Malocclusion:……..

Treatment planning:…….....

I, ……, have been fully informed by my physician about the current orthodontic problem, the necessary orthodontic treatment procedures, and the process regarding my treatment. You were given the opportunity to ask any questions about the proposed orthodontic treatment. I fully understand the risks associated with the treatment and the things I need to be careful about.

"I have read and understood this form. I approve the appropriate orthodontic treatment. "I accept the major treatment considerations I was told and the possible risks of orthodontic treatment." (This letter will be handwritten and signed by the patient/patient's parent in the field below.)

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(For patients who do not have legal capacity, it will be filled out by the patient's parent / legal guardian.)

Patient name-surname: …….....

Name and Surname of the Patient's Parent/Guardian:……..….(For patients under 18)

Date: …… **Sign:** …….....

This page will be filled in when deemed necessary by the physician!

Orthognathic Surgery Treatment;

"I accept the treatment planning in the form of orthognathic surgical intervention and assume responsibility for all risks and limitations. I Read-I Understand-I Approve."

(This letter will be handwritten and signed by the patient/patient's parent in the field below.)

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In the Presence of Impacted Teeth;

" In order to maintain my impacted……..tooth(s), I agree to have my …… tooth(s) extracted. I have read what is explained above and understand all the risks involved. I Read-I Understand-I Approve."

(This letter will be handwritten and signed by the patient/patient's parent in the field below.)

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"I accept having my impacted tooth(s)……..…extracted. I have read what is explained above and understand all the risks involved. "I Read-I Understand-I Approve."

(This letter will be handwritten and signed by the patient/patient's parent in the field below.)

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Patient name-surname: …….....

Name and Surname of the Patient's Parent/Guardian:……..….(For patients under 18)

Date: …… **Sign:** …….....