Name of the project: Dentist–Patient Communication on Dental Anxiety using the Social media and Timing in Communication: A Randomized Controlled Trial

Date: 2 April 2018

Signed Patient Release Form

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

Dental anxiety, a term used to describe fear, anxiety, or stress in a dental setting, is a very common phenomenon, and despite all the technological advances in dentistry, it remains an obstacle for many patients to seek appropriate dental care.

The ability to provide information on social media quickly enabled patients to be informed in the field of health.

In our study, the effects of social media use on dental anxiety will be examined. For this reason, the same scales (4 pieces) will be given before and after the surgical procedure and they will be asked to be filled. The study will be done only through scales.

Scales:

In the present study, the Spielberger's State-Trait Anxiety Inventory (STAI-T and STAI-S), Modified Dental Anxiety Scale (MDAS) and VAS scales, which provide useful information about patient anxiety and have a positive correlation, will be used for a comprehensive assessment of patient anxiety.

Both of STAI-S and STAI-T scales includes 20 questions. For each question, the scores range from 1 (almost never) to 4 (almost always) points.

The MDAS consists of 5 questions that measure anxiety at different stages of dental treatment. The options range from 1 (not anxious) to 5 (very anxious) for each question.

The VAS scale was included in the present study to determine how anxious the patientsfelt according to their own thoughts. Scores range from 0 (no anxiety) to 10 (extreme anxiety).

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I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

I. My Authorization

I authorize the following using or disclosing party:

_____

Signature of Patient: _____

Date: _____