

ORTHODONTIC TREATMENT

Patient Name: _____

Date: _____

You have the right and obligation to make decisions regarding your oral healthcare and that provided to you or your child. Your cooperation and participation in the decision making process is necessary. When undergoing orthodontic treatment there are certain risks and the potential for unsuccessful results. In order to minimize these outcomes, once treatment begins my complete cooperation and participation is necessary.

Appointments must be maintained as scheduled. Any delayed or missed appointments will prolong the treatment time and will inhibit the success of your plan. Instructions must be diligently followed with regard to oral hygiene and use of any adjunct appliances. The dental care team will instruct you on these issues; however, it is your responsibility to follow them as instructed.

Circumstances which are unforeseen at the start of the orthodontic treatment plan may occur. These include but are not limited to:

1. Decay, gum disease, decalcification (permanent markings on the teeth) may occur if the oral hygiene instructions are not followed properly. You will need to maintain checkups and dental care with your general dentist during the course of your orthodontic treatment plan.
2. Root canal therapy may be necessary to preserve a tooth when movement has revealed a non-vital tooth.
3. Temporal mandibular Joint Dysfunction (TMJ) can occur during the treatment. Should TMJ be exhibited, it will be necessary for the patient to see a TMJ specialist.
4. Root resorption may occur due to the application of force or movement of teeth back and forth as a result of prolonged orthodontic treatment. There are no long term consequences to root resorption unless there has been a greater than 50% loss of the root. In this case, stability of the teeth may be in jeopardy.

Once the orthodontic treatment has ended, there is the possibility of the teeth shifting. Retainers may be recommended by your dental care team along with instructions as to their use and care.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I understand the dental care team cannot make any promises or guarantees of the outcome or result. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Parent (or Legal Guardian) Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

SAMPLE