INFORMATIONAL PURPOSES ONLY

ORTHODONTIC TREATMENT

I UNDERSTAND that treatment of dental conditions pertaining to ORTHODONTIC TREATMENT (straightening or repositioning of teeth) includes certain risks and potential unsuccessful results. Even though great care and diligence will be used in treatment, no promises or guarantees for desired results can be made nor expected.

1. **Complete cooperation of the patient is essential.** Once treatment is begun, each appointment must be attended as scheduled. Each delayed or missed appointment will prolong the time necessary to complete treatment (which can never be precisely determined) and may create problems making it impossible to achieve the desired results.

2. **Instructions must be diligently followed.** There will be instructions given concerning special oral hygiene measures which must be followed. Also, as treatment progresses, certain adjunctive appliances may be necessary. Instructions will be given as to their care ant use which must also be followed exactly. Informational and instructional literature will be given. It is the responsibility of the patient to thoroughly study and understand this material.

3. **Decalcification (permanent markings on the teeth), decay, and/or gum disease** can occur if teeth are not brushed properly ant thoroughly during the treatment period. Sweets and between meal snacks must be eliminated, If desired results are to be achieved, this is absolutely necessary. Continuing checkups and dental care from the patient's general dentist during the course of treatment is essential.

4. **Teeth may become non-vital.** This is always a possibility, with or without orthodontic treatment. Trauma from a blow, deep fillings, etc. may cause the nerve tissue in a tooth to die. This can happen over a long period of time. Even though this problem may exist, it may be undetectable at the beginning of orthodontic treatment, but through tooth movement it may exhibit itself. Root canal treatment may then become necessary in order to preserve the tooth or teeth.

5. **Root resorption** is a condition where roots may become shortened during treatment. Under healthy conditions, this is no serious disadvantage. However, if gum disease occurs in later life, the longevity of the teeth could be compromised. Other conditions can cause root resorption such as: trauma, cuts, impaction, endocrine disorders, or idiopathic (unknown) reasons.

6. **Temporomandibular Joint (TMJ) dysfunction** can occur before, during or after orthodontic treatment. Many times the TMJ, even though the damage had begun long before the orthodontic treatment, because of the subtle changes in the bite through treatment, symptoms of this damage such as clicking, popping, crackling, pain, headaches, etc., may then become evident. Even though there were no apparent symptoms previously, these may begin to exhibit themselves during treatment. Should such symptoms occur, it may be necessary for the patient to be referred to a TMJ specialist.

7. **Shifting of teeth** might occur after braces are removed. For this reason, retainers are constructed which must be diligently worn for a period of time which will vary between patients. Retainers are made of materials that are subject to breakage no matter how well constructed. Retainers must be handled and used carefully. Repair charges may be made. Instructions will be given concerning these appliances.

8. **I recognize that it is my responsibility to follow instructions completely and seek attention in a timely manner should any unexpected problems occur by informing this office immediately. I must explicitly follow any instructions, either written or oral, which have been given to me relating to this orthodontic treatment.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of orthodontic treatment and have received answers to my satisfaction. I have been given the alternative of seeking care with an orthodontic specialist. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning any results from treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I accept all terms and conditions expressed within it and freely give my consent to authorize Dr. _____ and any and all associates necessary in rendering services that he/she deems necessary or advisable for this subject orthodontic treatment.

_____	_____	_____
Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date
	_____	_____
	Witness to signature	Date

(Rev. 1/1/96)