INFORMATIONAL INFORMED CONSENT
ORTHODONTIC TREATMENT

I UNDERSTAND that 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 or outcome can be made nor expected.

1. **Complete cooperation of the patient is essential.** Once treatment is begun, each appointment must be kept 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 and 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 and thoroughly during the treatment period. Sweets, between meal snacks and excessive sugar containing soft drink consumption 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. A pre-existing non-vital tooth, undetectable at the beginning of orthodontic treatment, may manifest itself through tooth movement and require additional treatment, most likely root canal therapy, in order to preserve the tooth or teeth.

5. **Root resorption** is a condition where roots may become shortened during treatment. If the resorption is minimal, there may be no serious disadvantage if proper hygiene is maintained. In rare cases, however, resorption can be moderate to severe and if this resorption is complicated by gum disease which may occur later in 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. Taking of bisphosphonate drugs for osteoporosis may also affect resorption or bone health.

6. **Temporomandibular Joint (TMJ) dysfunction** can occur before, during or after orthodontic treatment. Although damage to the joint may have started long before the orthodontic treatment commenced, because of the subtle changes in the bite that occur 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 dentist who focuses on treating TMJ symptoms.

7. **Shifting of teeth** might occur after orthodontic appliances (braces) are removed. For this reason, retainers are constructed which may be fixed in place 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. Removable retainers must be handled and used carefully and worn as instructed, possibly for many years. 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.**

9. **Failure to meet financial obligations, keep appointments, wear removable appliances as instructed, or failure to notify this office of broken appliances in a timely manner may be grounds for appliance removal and immediate termination of treatment with no further recourse.**

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. 1-08)