INFORMED CONSENT LIMITATIONS AND RISK OF ORTHODONTIC TREATMENT

Patient's Name_____ **Date** _____

Procedure(s)_____

The following information is routinely provided to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment like any treatment of the body has inherent risks and limitations. These are seldom enough to rule out treatment, but should be considered when deciding to wear orthodontic appliances. Please note that it is impossible to list every circumstance so this has to be considered an incomplete list. Please read this consent carefully and ask your Dentist to explain anything you do not understand. A certain amount of discomfort should be expected when orthodontic appliances are placed as well as at each adjustment appointment.

ROOT RESORPTION

In a very few cases, the ends of the roots of the teeth are shortened during treatment. In the event of subsequent gum disease this root end resorption could reduce the longevity of affected teeth. Under healthy circumstances, the shortened roots are at no disadvantage. It is nearly impossible to predict susceptibility to this condition.

RETURN OF ORIGINAL PROBLEM

Many problems tend to return by a factor of 10% or so, especially very severe problems. We will make our correction to the highest standards, and hold the result carefully. When the retention is discontinued, we will expect some return. Careful cooperation during the retention period will keep this rebound to a minimum.

DECALCIFICATION, DECAY OR MOST GUM DISEASE

These problems may occur if the patient does not cooperate with brushing or flossing. More frequent hygiene visits (every 3 months) are required to maintain oral tissue health unless otherwise indicated. These fees are over and above the orthodontic treatment plan. An estimate for the hygiene visits will be provided for you once the appropriate hygiene regime has been determined. Also essential is proper dietary control, with special attention to the amount and frequency of sugar in the diet. With adults, we ask for increased attention to prevention of gum disease. If periodontal disease occurs during the course of treatment, it may be difficult or impossible to control the bone loss and subsequent loss of teeth.

TREATMENT PROGRESS

Can be delayed beyond our forecast. Lacking of facial growth, gum disease, poor headgear operation, broken appliances, and missed appointments are all important factors.

ADDITIONAL TREATMENT

Unforeseen circumstances (growth changes, gum disease) may cause us to recommend a form of treatment not previously discussed. If this occurs, we will carefully explain the reasons for a change in the treatment plan and an extra fee before proceeding.

TMJ PAIN

Some patients are very sensitive to even a slight discrepancy in their bite. These patients may suffer from noise or pain in the joint of the lower jaw (near the ear). This may occur during or after orthodontic treatment. It also happens in patients who have never had orthodontic treatment. Let us know if you suspect a problem so we can deal with it. An imperfect bite may also cause TMJ problems. Often orthodontic therapy alone cannot result in an absolutely perfect bite because of the complex factors influencing the alignment of teeth.

DEVITALIZATION

It is possible for a tooth to die during orthodontic treatment, especially if it was previously injured or was impacted. Sometimes such injuries are unknown to the patient or parents. Previous injuries can not be detected by the orthodontist.

For that reason, a tooth may die and the reason for it may not be apparent. Root canal treatment may be recommended if you have such a problem. Extraction is usually not necessary.

SUCCESS OF TREATMENT

We intend to do everything possible to provide the best result in every case and it is our opinion that the treatment will be beneficial. However, we cannot guarantee that the proposed treatment will be successful or to your complete satisfaction. Due to individual patient differences, there exists a possibility of failure, relapse, or selective re-treatment, despite the best of care. Much of the success of the treatment depends on the understanding and cooperation of the patient.

INVISALIGN

During the process of the treatment you will receive several appliances to be worn 24 hours and only removed to eat, drink, brush, floss and clean the appliances. Please avoid eating or drinking anything with the appliances in place (ie: gum chewing). The *green* box indicates the appliances to start with, the *red* box indicates appliances completed. You will be required to wear a set of appliances for approximately 2 week intervals. Monthly appointments are required to monitor the treatment progression. An accurate system of appliance change must be followed to provide a successful treatment outcome. Failure to follow this regime will result in treatment delays. Retainers will follow the active orthodontic phase. Please place the appliances in a safe COOL place when not worn, a fee will be charged to replace lost or mistreated appliances.

PAYMENT POLICIES

We have set-up a payment schedule for your convenience. Please keep in mind that your account must either be paid in full or be current at the time the bands are removed.

PLEASE NOTE:

ANY ADDITIONAL TREATMENT OR ROUTINE DENTAL CARE FEES ARE OVER AND ABOVE THE ORTHODONTIC TREATMENT FEES (ie: hygiene,extractions,fillings).
YOU WILL EXPERIENCE LOOSE TEETH AND SENSITIVITY FOR 3 TO 10 DAYS FOLLOWING PLACEMENT AND ADJUSTMENT OF ORTHODONTIC APPLIANCES.

INFORMED CONSENT AND TREATMENT AUTHORIZATION

I have read, and understand, the above and have had the opportunity to discuss it with Dr. Aram Mohajer to clarify any areas I do not understand.
I authorize Dr. Aram Mohajer to provide orthodontic treatment for:
The prescribed treatment was explained to me on:

I FURTHER UNDERSTAND THAT, LIKE OTHER HEALING ARTS, THE PRACTICE OF ORTHODONTICS IS NOT AN EXACT SCIENCE THEREFORE, RESULTS CANNOT BE GUARANTEED.
I HAVE BEEN PROVIDED WITH A COPY OF THIS INFORMED CONSENT:

_____ _____

Patient/Parent/ or Guardian signature **Date**

_____ _____

Doctor's signature **Signature of witness**