

ORTHODONTICS

Orthodontics is the treatment of malocclusion, or an improper bite. It plays an important role in improving overall oral health. Having properly aligned teeth, which are easier to brush, may decrease the tendency for decay or for developing diseases of the gum and supporting bone.

Patient's
Initials

- _____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.
- _____ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.
- _____ I am aware that properly aligned teeth also help minimize excessive stress on bones, roots, gum tissues, and the temporomandibular joints (TMJs).
- _____ I am aware that orthodontic treatment has limitations and potential risks. Patients may respond differently to treatment. Orthodontic outcomes and results cannot be guaranteed.
- _____ I am aware that the major risks involved in orthodontic treatment may include, but are not limited to:
- _____ ***Decalcification (permanent enamel markings):*** Tooth decay, gum disease, and permanent markings (decalcification) on the teeth can occur if I eat foods containing excessive sugar and/or do not brush my teeth frequently and properly. These same problems can occur without orthodontic treatment, but the risk is greater to me as an individual wearing braces or appliances.
- _____ ***Root Shortening:*** In some patients, the length of the roots may be shortened during orthodontic treatment. I may or may not be prone to root shortening. Usually, this does not have significant consequences, but on occasion it may become a threat to the longevity of the teeth involved.
- _____ ***Relapse Tendency:*** Teeth may have a tendency to change position after orthodontic treatment. This is usually only a minor change, and faithfully wearing retainers as instructed should help reduce this tendency. Throughout life, the bite can change adversely from various causes, such as eruption of wisdom teeth, growth and/or maturational changes, mouth breathing, playing musical instruments, and other oral habits, all of which may be out of the control of the orthodontist.
- _____ ***Jaw Joint Problems:*** Occasionally, problems may occur in the jaw joints, causing joint pain, headaches, or ear problems. These problems may occur with or without orthodontic treatment. Any of the above-noted symptoms should be promptly reported to the orthodontist.
- _____ ***Loss of Tooth Vitality:*** Sometimes a tooth may be traumatized.
- _____ ***Postadjustment Pain:*** Usual postadjustment tenderness should be expected, and the period of tenderness or sensitivity varies with each patient and the procedure performed. Typical post-adjustment tenderness may last 24 to 48 hours. You should inform our office of any unusual symptoms or broken or loose appliances as soon as they are noted.

- _____ **Minor Injuries:** Sometimes orthodontic appliances may be swallowed or aspirated accidentally or may irritate or damage oral tissues. The gums, cheeks, and lips may be scratched or irritated by loose or broken appliances or by traumatic blows to the mouth. On rare occasions, when dental instruments are used in the mouth, the patient may inadvertently receive scratches or enamel abrasions, be poked, or receive a blow to a tooth that can potentially damage or cause soreness to affected oral structures. Abnormal wear to tooth structure is also possible if the patient grinds his or her teeth excessively. We will use extreme care to avoid injury.
- _____ **Headgear Instructions:** If headgear is necessary, improperly handled headgear may cause injury to the face or eyes, or even cause blindness. There have been a few reports of injury to the eyes of patients wearing headgear. Patients are warned not to wear the appliance during times of horseplay or competitive activity. Although our headgears are equipped with a safety system, we urge caution at all times.
- _____ **Adjunctive Surgery:** Sometimes oral surgery, tooth removal, or orthodontic surgery is necessary in conjunction with orthodontic treatment, especially to correct crowding or severe jaw imbalances. Risks involved with treatment and anesthesia should be discussed with your general dentist or oral surgeon before making your decision to proceed with this type of procedure.
- _____ **Unfavorable Growth:** Uncommon formation of teeth or abnormal changes in the growth of the jaws may limit our ability to achieve the desired result. If growth becomes unbalanced during or after treatment or if a tooth forms very late, the bite may change, requiring additional treatments or, in some cases, oral surgery. Growth issues and unusual tooth formations are biological processes beyond the orthodontist's control. Growth changes that occur after orthodontic treatment may alter the quality of treatment results.
- _____ **Treatment Time:** The total time required to complete treatment may exceed the original estimate. Too much or not enough bone growth, poor cooperation in wearing the appliance(s) for the required hours per day, poor oral hygiene, broken appliances, and missed appointments can lengthen the treatment time and affect the quality of the end results.
- _____ **Ceramic Braces:** When clear and tooth-colored brackets (ceramics) have been utilized, there have been some reported incidents of patients experiencing bracket breakage and/or damage to teeth, including erosions, flaking, or cracking. Fractured brackets may result in small ceramic pieces breaking off—which might be harmful to the patient, especially if swallowed into the stomach or lungs.
- _____ **Adjunctive Dental Care:** Due to the wide variation in the size and shape of teeth, achieving the most acceptable result (for example, complete closure of excessive space) may require restorative dental treatment (in addition to orthodontic care). The most common types of treatments are cosmetic bonding, crown and bridge restorative dental care, and/or periodontal therapy. You are encouraged to ask your dentist about other dental care you may need to achieve the best results.
- _____ **Nerve Damage:** A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth.

- _____ **Allergies:** Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.
- _____ I understand that if no treatment is undertaken, any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, looseness, or drifting teeth followed by necessity of extraction. Also possible are TMJ problems.
- _____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.
- _____ I request and authorize dental services for me, including orthodontics.
- _____ I fully understand that during and following the contemplated dental procedure, oral surgery or treatment, conditions may become apparent that warrant, in the judgment of my dentist/oral surgeon, additional or alternative treatment in order to achieve a successful outcome. I also approve any modifications in design, materials, or care thought to be in my best interest or to improve my outcome.
- _____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics.
- _____ I am aware that occasionally speech can be affected by oral surgery/dental procedures. I am aware that further soft tissue surgery is sometimes necessary to improve the final outcome.
- _____ I am aware that smoking during the pre- and post-treatment periods could increase chances of complications (if applicable).
- _____ I understand that excessive smoking, use of alcohol, or sugar may affect gum healing and may limit the success of my procedure. I agree to follow my doctor's home care instructions and to report to my dentist for regular examinations as instructed.
- _____ I realize that my own proper hygiene is critical to the future success of my treatment plan and that I must maintain good oral hygiene. Like normal dentition, the desired outcome of this procedure may be affected by lack of oral hygiene and may actually be reversed due to neglect.
- _____ I have informed everyone participating in my dental treatment of all my known allergies.
- _____ I have informed everyone involved in my dental treatment of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ To my knowledge, I have given an accurate report of my physical and mental health history, including any prior allergic or unusual reaction to drugs, food, insect bites, anesthetics, pollens, dust, abnormal bleeding, or any other condition.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect postoperatively and of the possibility of additional procedures.
- _____ I understand that any tissue/specimen removed during treatment may be sent to pathology for evaluation (if applicable).

_____ Pre- and post-treatment photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the treating dentist (if applicable).

_____ I agree to the type of anesthesia—local or general—administered intravenously, intramuscularly, orally, or by inhalation. I agree not to operate a motor vehicle or hazardous device for at least 24 hours (or more) until I am fully recovered from the effects of anesthesia or drugs given for my care. I am aware that possible anesthesia risks include inflammation of veins and allergic reactions caused by my drugs or medications.

_____ I am satisfied with the answers I have received to all of my questions regarding this procedure, and I understand the terms of this agreement.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, DDS/DMD/MD, with associates or assistants of his or her choice, to perform the following procedure:

on _____
(Patient Name)

at _____
(Facility Name)

on the _____
(Left, right, level, body part)

I further authorize the dentist(s)/orthodontist(s) and any assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe the patient/legal representative (circle one) fully understands what I have explained.

Dentist/Orthodontist Signature/Date/Time

_____ Copy given to patient
initial

_____ Original placed in patient's chart
initial