Discussion and Consent for Orthodontic Treatment

Patient Name: ____ Date: ____________________________________

Diagnosis: ____

Treatment: ____

Facts for Consideration

Patient's initials required

________ Bands are cemented on and/or brackets are bonded onto the surface of teeth to serve as anchors for the braces. Brackets are then used to hold one or more arch wires in place. The combination of the arch wire and bracket facilitate the movement of teeth. If all teeth have not yet erupted, bracket placement may be minimal.

________ An arch wire is a thin metal wire and is the primary component that will move the teeth by applying pressure on the tooth or teeth. This wire may be changed and adjusted on a regular basis. Arch wires are held in place by the brackets or by tying a small wire or elastics around the brackets.

________ Elastics are small rubber bands that are stretched between two or more of the teeth to provide extra force in a specific direction. Elastics and headgear tied to the braces may also be used to facilitate the alignment of teeth. Headgear is a strap and metal device that slides into tubes that can be attached to the back molar (tooth) bands.

________ Clear aligners are another option to orthodontically treat a patient. If deemed a candidate by an orthodontist/general dentist, a series of clear aligners can be used to gradually shift teeth into place. Interproximal reduction (IPR) may be recommended to make space or to correct tooth size discrepancies. Certain movements of teeth may require bonded temporary attachments to some teeth surfaces.

Benefits of Orthodontic Treatment, Not Limited to the Following:

________ The goal of orthodontic treatment is intended to help improve the bite (alignment and position of teeth) by helping to direct pressure placed on the teeth. Properly aligned teeth can minimize excessive stress on bones, roots, gum tissues and the temporomandibular (jaw) joints. Orthodontic treatment can assist in reducing future dental problems such as abnormal wear. Treatment can facilitate good oral hygiene that in turn can minimize decay and the potential for future periodontal (gum) problems. In addition, orthodontics can promote a pleasant smile, which may enhance one's self-image.

Risks of Orthodontic Treatment, Not Limited to the Following:

________ I understand that as a result of having braces, there is an increased risk of conditions such as tooth decay, gum disease and permanent tooth markings (decalcification) may happen to the teeth particularly if foods are eaten that contain excessive sugar and/or there is poor home care (e.g., the teeth are not brushed and flossed regularly).

________ I understand that because of having braces, the length of the roots of teeth may be shortened (root resorption) for some patients. Some patients are more prone to resorption than others, but this cannot always be determined in advance. Usually this does not have significant consequences, but on occasion, it may reduce the longevity (lifespan) of the teeth involved. You are advised to have routine X-rays taken during the course of treatment. If root resorption is noted during treatment, treatment may need to be paused or halted before completion.

________ I understand the health of the bone and gums, which support teeth, may be affected by orthodontic tooth movement, particularly if a preexisting condition is present and also in some rare cases where a preexisting condition is not apparent. In general, orthodontic treatment lessens the chance of tooth loss or gum infection. Inflammation of the gums and loss of supporting bone can occur if bacterial plaque is not removed daily with good oral hygiene (home care). During active orthodontic treatment, you should have your general dentist or periodontist monitor your periodontal (gums) health and have routine X-rays taken at least every six months or as individually advised. Orthodontic treatment may need to be stopped if periodontal issues cannot be controlled.

________ I understand teeth may change their positions after orthodontic treatment is completed. These are usually minor changes, which faithful use of retainers as instructed can help minimize. Habits such as, but not limited to, tooth grinding, tongue thrusting and mouth breathing can cause changes in the bite.

________ I understand the total time required to complete orthodontic treatment may exceed the original estimate. Success strongly depends upon patient compliance. Excessive or deficient bone growth, poor or inadequate cooperation in wearing the appliance(s) (headgear, elastics, etc.) the required hours per day, poor oral hygiene, broken appliances or missed appointments can lengthen the treatment time and affect the quality of the final results. Additional fees may be charged if treatment exceeds the estimated treatment time.

________ I understand that on occasion, atypical (unusual) formation of teeth or insufficient or abnormal changes in the growth of the jaws may limit the ability to achieve the desired result. If the growth of either jaw is disproportionate to the other, the bite may change and in some cases may require removal of teeth or even orthognathic (jaw bone) surgery to correct the growth disharmony. Growth and unusual tooth formations are biological processes beyond the orthodontist's/general dentist's control. Growth changes that occur after orthodontic treatment may alter the quality of treatment results.

________ I understand that on occasion orthodontic appliances may cause irritation or damage to the oral (gums, cheeks, tongue and palate) tissue. Sometimes appliances may accidentally be swallowed or aspirated. These occurrences are rare if instructions are followed properly. Traditional headgear if improperly handled may cause significant injury to the face or eyes, even blindness. In cases of misuse or abuse of the orthodontic hardware and/or elastics, there have been reports of permanent injury to the eyes of patients wearing headgear. Breakaway headgear has a releasable latch, which disengages predictably and easily when the facebow (front part or bar) is pulled forward. Patients are warned not to wear the appliance while participating in team sports, horseplay or competitive activity involving any kind of physical contact.

________ I understand that the gums, cheeks and lips may be scratched or irritated by loose or broken appliances or by traumatic blows to the mouth. Post-adjustment tenderness is typical, 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 occur.

________ I understand all necessary regular dentistry (fillings, cleanings, caps/crowns) should be completed prior to starting orthodontic treatment. Regular checkups, X-rays and cleanings with a general dentist are necessary throughout orthodontic treatment and will not be performed by your orthodontist. Failure to follow this instruction may result in injury to or loss of teeth.

________ I understand some allergies to orthodontic materials may occur in a small percentage of patients. Notifying the orthodontist/general dentist of any known allergies can reduce the chance of an allergic reaction occurring. I will inform the office of any unusual symptoms of allergic reaction that could be caused by orthodontic appliances or hardware.

________ I understand that clear aligners require at least 22 hours of daily wear to keep tooth movement on track. Failure to adhere to this requirement may result in delay or failure of clear aligner treatment. In order to achieve the desired outcome additional orthodontic treatment including brackets, buttons, orthodontic elastics and/or restorative work may be needed as part of this treatment.

________ Restorations may come off and need to be replaced or recemented. Teeth that have large restorations or that have been traumatized may be aggravated to the point of needing endodontic treatment or more restorative work.

________ I understand that problems may arise during orthodontic treatment with the TMJ (jaw joints) such as pain, headaches and locking upon opening and/or closing. Problems can be caused by many components such as heredity, trauma, clenching, tooth grinding, arthritis or poor bite issues. Symptoms should be promptly reported to our office.

Consequences if No Orthodontic Treatment Is Administered, Not Limited to the Following:

________ I understand that if no orthodontic treatment is performed, I may continue to have existing bite problems, symptoms and the cosmetic (alignment) appearance of my teeth will remain the same.

Alternative Treatments if Orthodontic Treatment Is Not the Only Solution, Not Limited to the Following:

_______ I understand that any specific alternative to the orthodontic treatment of any particular patient depends on the nature of the individual's teeth, supporting structures and appearance. Options to treatment may include 1) surgical extractions, 2) orthognathic surgery, 3) temporary anchorage devices (TADs), 4) prosthetic solutions such as bridges, implants and partial dentures and 5) other compromised approaches as discussed. I have asked my orthodontist/general dentist about and have been informed of the alternatives and associated expenses. I have had an opportunity to ask questions and my questions have been answered to my satisfaction regarding the procedures, their risks, benefits and costs.

Alternatives Discussed: ____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks, benefits and alternatives of the proposed treatment.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct this dentist to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

____ ______________________

Patient or Patient's Representative Date

____ ______________________

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with
______________________ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

____ ______________________

Dentist Signature Date