



0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DEPARTMENT OF ORTHODONTONICS - CONSENT FOR ORTHODONTIC TREATMENT

Date Consent Obtained: _____

I have received information about my condition, the proposed treatment, alternatives and related risks. I understand that this form contains a brief summary of that information. I have received all the information I wish and my questions have all been answered. I understand that I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the related matters described below.

I request and authorize Dr. _____, and such other dentists and physicians working with him/her, to treat (including further diagnosis and any needed photographs of) my condition. **I UNDERSTAND THAT PHYSICIANS OR DENTISTS IN TRAINING MAY PERFORM PORTIONS OF THE PROCEDURES DESCRIBED BELOW UNDER THE PARTICIPATORY SUPERVISION OF MY ATTENDING PHYSICIAN OR DENTIST.** I understand my condition to be:

I understand and request the following proposed orthodontic treatment(s): _____

I have been informed of alternative conditions that may be discovered and alternative and/or additional procedures that may be necessary. I consent to the performance of the procedures determined by my dentist to be in my best interest.

I understand the risk associated with the proposed orthodontic treatment to be:

- **Tooth decay, gum disease and permanent markings** (decalcification) on the teeth if teeth are not properly and regularly cleaned, as well as inflammation of the gums and loss of supporting bone if bacterial plaque is not removed daily with good oral hygiene (cleaning).
- **The length of roots of the teeth may be shortened** during orthodontic treatment; trauma to a tooth may also increase this risk; and, shortened roots may mean teeth die earlier than they normally would.
- **Teeth may change their positions after treatment** is completed. Note that throughout life tooth position is constantly changing and a person's bite may change with the eruption of wisdom teeth or growth and /or maturational changes, oral habits, as well as other factors affecting the oral cavity (mouth). In order to have the best chance of maintaining a stable alignment of teeth after braces are removed, retainers must be worn throughout one's lifetime.
- **Jaw-related problems** – Sometimes problems may occur in the jaw joints (Temporomandibular Joints - TMJ), causing joint pain, limited opening of the mouth, headaches or ear problems. If such problems occur, your orthodontist should immediately be consulted. Orthodontic tooth movement may aggravate a tooth that has been traumatized previously, or where a tooth that has a large filling. In such instances, root canal treatment may be necessary.
- **Swallowing or aspiration** of orthodontic appliances, including brackets, may occur.
- **Irritation to oral tissues** – Orthodontic appliances may irritate or damage oral tissues. Gums, cheeks and lips may be scratched or irritated by loose or broken appliances or by blows to the mouth. Moreover, anytime orthodontic appliances are adjusted, there is likely to be tenderness, which typically last for 24 to 48 hours. Should you have unusual symptoms, broken or loose appliances, or like problems, you should immediately notify your orthodontist. Sometimes dental instruments used during orthodontic treatment may scratch, rub or similarly poke a tooth or gum causing some discomfort and potential for tooth or gum damage. It should also be understood that if the patient grinds his/her teeth, there might be damage to the patient's teeth.
- **Safety measures** – Patients should not wear orthodontic headgear/appliance during sports, horseplay or other similar rough activity. In such instances there is a risk of damage to the face, including eyes and even blindness can result. Caution and safety should always be exercised when wearing orthodontic headgear.
- **Additional procedures may be necessary** – A patient's growth changes during and after orthodontic treatment may alter the treatment result and/or may limit the ability to achieve the desired result. Growth changes may change the bite and require additional treatments, including the possibility of oral surgery. Due to the wide variation in the size and shape of teeth, achievement of the most ideal result (for example: complete closure of excessive space) may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy. You will need to consult your dentist about such additional treatments.
- **General medical problems can effect orthodontic treatment. You should tell your orthodontist of any problems with, or changes in, your medical health.**

I understand the alternatives and related risks to the proposed procedures to be: Not to undergo orthodontic treatment (risks include potential tooth/gum injury or deterioration due to continued misalignment of teeth).



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B. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE PRINTED NAME DATE TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:		
<input type="checkbox"/> 1. Agent Named in Advance Directive	<input type="checkbox"/> 4. Adult Child	<input type="checkbox"/> 7. Other Blood Relative
<input type="checkbox"/> 2. Guardian	<input type="checkbox"/> 5. Parent	<input type="checkbox"/> 8. Other* _____
<input type="checkbox"/> 3. Husband/Wife	<input type="checkbox"/> 6. Adult Brother/Sister	
FOR MINOR PATIENTS:		
<input type="checkbox"/> 1. Parents	<input type="checkbox"/> 2. Guardian or Legal Custodian	<input type="checkbox"/> 3. Authorized person for child in out-of-home placement

* Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.

C. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT PRINTED NAME PIC # DATE TIME

SIGNATURE OF WITNESS (OPTIONAL)
REQUIRED FOR TELEPHONE CONSENTS PRINTED NAME DATE TIME

D. INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID # PRINTED NAME DATE TIME