INFORMED CONSENT

For Orthodontic Treatment of _____ **Date** _____

I understand that:

1. **a.** Orthodontic treatment may fail to reach an ideal result.
   b. Retention of orthodontic treatment is subject to factors beyond the control of the orthodontist.
   c. A limited number of orthodontic problems fail to respond to mechanical treatment.
   d. Unfavorable reactions to teeth, bone and gums during orthodontic treatment or the retention treatment may occur. The most common are pain, swelling, tooth mobility, decay, etching, devitalization, bone loss, gum and bone recession, root resorption, lower jaw joint problems, swallowing of an appliance, bite difficulties, infection, relapse and injury by removable appliances and/or headgear.
   e. Lack of patient cooperation is the most common cause for excessive treatment. Init._____

2. Since most patients are of school age, it is necessary to have some appointments during school hours. We will try to alternate these appointments between school and after school hours whenever possible. Appointments for bandings require more time, therefore, this appointment will be scheduled at specific times. We do understand the difficulties involved in missing school classes and ask your cooperation in this matter.

   Init._____

3. I understand my responsibilities in maintaining a well-balanced soft-textured diet which is free of hard, sticky, stringy and high sugar foods, as well as supervising my (child's) oral hygiene program: of at least brushing three times daily. I will take my child to our family dentist for examinations at six month intervals and/or dental care as may be needed during orthodontic treatment. I will also report immediately any faulty appliances and supervise the wearing of any supplemental appliances or retainers as instructed.

   Init._____

4. Retreatment of orthodontic problems due to factors beyond the control of the orthodontist is NOT included in this contract.
   Init._____

5. General dental care during orthodontic service is entirely in the hands of your regular dentist and regular six month examinations must be made by you, as we assume no responsibility for this.

   Init._____

6. In the event you transfer out of our office, the amount of treatment rendered will be determined
   Depending on your individual case, a refund to you or final payment to us will be made based on the following formula:
   25%-Earned at the time of banding
   50%-Earned in the first 9 months
   100%-Earned in the first 12 months
   (Less Retention)
   Init._____

Signature _____ _____

(Patient-Parent-Guardian) (Witness)

Date _____