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INFORMED CONSENT FOR ORTHODONTIC TREATMENT

PATIENT'S NAME: _____

I hereby authorize all necessary orthodontic treatment be given for the above patient. This shall include the taking of necessary diagnostic records. I understand that all records may be used for reproduction in scientific publications for exhibit under the auspices of a scientific group and for teaching purposes.

I understand that orthodontic treatment cannot succeed _____/_____
through the efforts of the dentist alone, but rather through the joint cooperation of all parties involved and together we may achieve the best possible result. In many instances, lack of cooperation in the requested use of headgear, elastics, retainers, and positioners will make a successful completion of treatment or maintenance result impossible.

I understand that treatment time varies with the difficulty _____/_____
of the problem, cooperation of the patient, and individual physiologic response to treatment. Treatment time can be prolonged by broken appointments, broken appliances, poor oral hygiene, and poor diet. I further understand that for the best orthodontic result, progress records may be taken to evaluate treatment and make a progress diagnosis which may involve a change in the treatment plan. Occasionally, due to lack of cooperation and/or the severity of the problem, a rediagnosis may require maxillofacial surgery and/or selected teeth to be removed to obtain the best possible result for your child.

I understand that during orthodontic treatment there is a possibility the following may occur: cold sores, canker sores, irritation to the oral mucosa or skin, periodontal involvement, decalcification, decay or staining under or around the orthodontic appliance, tooth sensitivity and temporomandibular joint problems, possible need for crown and/or bridgework, or possible need for endodontic and/or periodontal treatment.

I understand the importance of maintaining a well-balanced diet which is free of hard, sticky and high-sugar foods as well as maintaining a proper hygiene program.

_____/_____

I understand that regular dental check ups are necessary to check for decay and clean the teeth. It is also my responsibility to immediately report any broken appliances and ensure the wearing of any supplemental appliances or retainers as instructed. If it becomes evident that further orthodontic treatment will endanger oral health or if lack of cooperation will prevent a satisfactory result, treatment may be discontinued.

A daily fluoride rinse such as that which may be obtained at the local pharmacy without a prescription is a must to help prevent an increase in decay rate. _____/_____

I understand that Dr. Talbot Sklar will use his knowledge, skill and training to do his very best but there is no guarantee of success of treatment and that varying degrees of relapse is possible. _____/_____

I understand that this practice is limited to pediatric dentistry which includes orthodontics or braces. Dr. Sklar has the training and experience to provide orthodontic treatment which is comparable to that which could be obtained by a dentist who provides only orthodontics. You have the option of seeking a second opinion and/or having the treatment performed by an orthodontist.

I understand what the problems are and the reasons for treatment. The alternatives have also been explained to me, one of which is no treatment and possible results if nothing is done. The treatment plan and types of appliances to be used have been explained to me. _____/_____

I understand the variables associated with the degree of success to be achieved and have read and understand the above. _____/_____

Date

Parent/Guardian Signature

Parent/Guardian Signature