

Talbot A. Sklar, D.D.S.

PATIENT COOPERATION AGREEMENT

In order to obtain the best possible results in my orthodontic treatment, and to finish as soon as possible, I _____, understand that my cooperative efforts are just as important as the efforts of Dr. Sklar and his staff. The doctor provides the treatment plan, and it is my responsibility to follow his instructions so that I may have beautiful healthy teeth that will last a lifetime. I will have done my part when I have taken responsibility for the following:

1. **Clean teeth and gums:** I will clean my teeth and gums properly three times a day, especially after eating meals and snacks, and use a fluoride rinse if prescribed.
2. **Wearing Appliances:** If I need to wear a headgear (night brace), elastics or other removable appliances I will cooperate fully as directed by the doctor and staff.
3. **Care of appliances:** I will not eat any foods or get involved in any activities that will damage my appliances and delay my treatment.
4. **Appointments:** I will try to keep all my appointments and arrive on time. I will call as soon as possible if I must change my appointment, and always call ahead of time if I have something broken or loose. I will take my fair share of appointments during school hours.

As an orthodontic patient receiving treatment in the office of Dr. Sklar, I agree to cooperate by following all of the above instructions.

Patient's signature

Date

Parent's signature

Date