Consent Form: Orthodontic Treatment

The goal of orthodontic treatment is to achieve improvement in the position of the teeth, the occlusal relationship, in the function and the aesthetic condition of the teeth and face.

Name of patient: _____ _____ _____ _____

Last Name | First Name | Father's Name | I.D.

I declare and confirm that I received detailed verbal information from:

Dr. _____ _____

Last Name | First Name

regarding orthodontic treatment in the upper jaw / lower jaw/ both jaws – in accordance with the detailed treatment plan that was presented to me on _____ (date): (Hereinafter: the **"Principal Treatment"**).

I was informed of the goals of the treatment, estimated duration of treatment, methods of treatment and appliances involved. I was presented with alternative treatment techniques which are possible under the circumstances of the case. The alternative treatment techniques have been considered by me before choosing the Principal Treatment.

I was also informed of the side effects of the Principal Treatment, including: Sensation of pressure, sensitivity and temporary mobility of the teeth, discomfort up to injury of oral tissues and gum swelling.

Furthermore, I was informed of the possible risks and complications of the Principal Treatment, including: Some resorption of the dental roots, loss of tooth vitality, injury to the supporting structures of the tooth (periodontium) and sensitivity of the jaw joints, the meaning of which was explained to me.

I am aware of the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff/doctor, including the need to maintain strict oral hygiene during the treatment, in order to avoid formation of tooth stains and/or caries, proper use of the orthodontic appliance, receiving all necessary operative and prosthetic treatments.

During the period of regular visits to the orthodontist, it is necessary to visit your regular dentist for checkup at least once every six months or as may be recommended and to visit the dental hygienist for regular treatment.

It was explained to me that the duration of treatment and achievement of the hopeful result depend, among other things, on the initial malocclusion, the changes associated with growth process (which may lead to the development of a new malocclusion) and on cooperation on my part. These factors might have an impact on the hopeful result, on the prolongation of the treatment and/or on the termination of treatment before completion.

It was explained to me and I fully understand that during the Principal Treatment, it might become necessary to change the treatment plan, in whole or in part, including additional treatments which cannot be fully anticipated, including change of orthodontic appliance.

I was informed that despite the procedures taken to preserve the position of the teeth (including the use of fixation or orthodontic retainer at the end of the treatment), there might be a regression in the position of the teeth. I was explained that should I fail to wear the orthodontic retainer according to the instructions provided to me, there might be a regression in the position of the teeth. I was also explained that the orthodontic appliance might disconnect or break. I am aware that in such case, I must turn to the clinic as soon as possible. I was also informed that in the event of unexpected changes in the jaws or teeth after treatment, a new malocclusion might occur.

I hereby give my consent to the Principal Treatment.

_____ _____

Date | Patient's Signature

_____ _____

Name of Guardian (relationship) | Guardian's Signature (When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____

Name of Physician | Signature | License No.

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The Medical Risk Management Company