ORTHODONTIC TREATMENT CONSENT

As with all dental treatment, treatment has possible risk to the dental structures. A discussion of the following potential risks specific to the type of malocclusion and treatment planned was held at the second consultation visit on (date from treatment history). The possible risks are not limited to this list, but these were felt to be the most common at the start of treatment. All efforts will be made to detect and limit any such damage.

Root Resorption: Shortening of the tooth during orthodontic treatment. Since there is no method of predicting which cases will have noticeable root resorption, progress x-rays may be requested during treatment to evaluate the condition of the tooth roots. Failure of the patient to allow such screening x-rays will not allow the detection of the problem early in treatment, and eliminating the chance to change the treatment objectives and treatment plan to reduce the potential damage to the teeth.

Bone or tooth loss: Orthodontic appliances compromise the ability of the patient to clean their teeth and gums properly. Additional effort is required of the patient to maintain their teeth, gums, and supporting bone during the treatment time. Failure to do this can result in gingivitis and periodontitis with a loss of supporting structures. In extreme cases, tooth loss is possible

Gingival recession: Movement of teeth and lack of good dental care by the patient can lead to gingival recession. In severe cases, gingival grafting during or after orthodontic treatment may be necessary.

Tooth decalcification: The lack of diligent dental hygiene during orthodontic treatment can lead to decalcification of the dental enamel, leaving white streaks or spots. These marks are permanent and can only be corrected by placing white dental fillings or porcelain crowns. In extreme cases of prolonged neglect, or in patients susceptible to dental decay, the decalcification can break through the enamel covering of the tooth, resulting in the need for restorative (fillings or crowns) work.

Incomplete bite correction: Patient compliance with the treatment instructions is of utmost importance to the success of the treatment. A lack of patient compliance and/or the inherent skeletal resistance of the malocclusion can result in an incomplete bite correction.

Poorly angled front teeth: Due to skeletal resistance or unexpected growth during treatment, it is possible for the front teeth to finish in a retruded position with the teeth angled back into the mouth. This is predictable in the patients that refuse surgical assistance to the correction of their malocclusion.

TM joint symptoms: There may already be damage to the jaw joints before treatment has started, even if symptoms were not initially present. Changing the bite can aggravate these damaged joints, resulting in pains to the head, jaws, and face.

More orthodontics due to maturation: Growth may continue after the completion of active orthodontic treatment, disrupting the final treatment occlusion. In severe cases, retreatment may be necessary to re-establish the correct bite after growth is completed. In class malocclusions, the severity can be such that surgery to the jaws may be required to correct the bite.

Open contacts after orthodontics: Spaces between the teeth must be made to fit the orthodontic bands. After treatment, almost all of these spaces close either spontaneously or by the orthodontic retainer. In some cases, spaces open and in other cases the spaces fail to close. The usual treatment is to place a filling or crown to keep food from packing between the teeth.

Surgery: Surgery may be a part of your treatment, including, but not limited to tooth extraction, gingival grafting, corticotomy, and orthognathic (jaw) surgery. The usual risks associated with dental surgery include excessive bleeding, loss of flaps with exposed bone and delayed healing, damage to the teeth, nerve damage, and loss of tooth vitality.

Change in treatment plan: Although the best effort has been made to make the most complete diagnosis and the most accurate treatment decision, it is possible that changes in the treatment plan may be required during treatment to reach the listed treatment goals. If consent is not given for the recommended treatment, even if not included in this initial treatment plan, the dentist cannot be held responsible to reach the listed treatment goals.

Non-specialist: The doctor is not a specialist in orthodontics, although he has a special interest in this part of the profession. The complexity of the case has been carefully considered before accepting the case for treatment. The patient/parent has been offered the referral to a specialist, and requests the treatment from this dentist instead, understanding the training to be less than the specialist.

The goals, limitations, and treatment alternatives, and risks have been presented to me, and I request treatment as suggested. Photographs and x-rays may be used for professional journal publication, seminars, websites, and other professional uses.

_____ **Date** _____

patient/parent

_____ **Date** _____

Staff member or Doctor