CASCADE FAMILY DENTAL

The Powerprox Six Month Braces

INFORMED CONSENT

Our goal is to accomplish a high quality cosmetic orthodontic result in a reasonable time frame for our adult patients. Since orthodontic treatment is extended over a period of time, however it is essential that a close and cooperative relationship exist between you and our office. To support these objectives, we ask that you:

1. **Complete cooperation of the patient is essential**. Once treatment is begun, each appointment must be kept as scheduled. Each delayed or missed appointment will prolong the time necessary to complete treatment

2. **Instructions must be diligently followed.** There will be instructions given concerning special oral hygiene measures which must be followed. Also, as treatment progresses, certain adjunctive appliances may be necessary. Instructions will be given as to their care and use which must also be followed exactly. Informational and instructional literature will be given. It is the responsibility of the patient to thoroughly study and understand this material. *I understand that additional charges (beyond the quoted orthodontic treatment fee) will be made for splinted retainers, lost appliances, broken appliances, repeated recementation of braces due to patient non-compliance and missed appointments. These events may also lengthen treatment time.*

3. **Decalcification (permanent markings on the teeth), decay, and/or gum disease** can occur if teeth are not brushed properly and thoroughly during the treatment period. Sweets, between meal snacks and excessive sugar containing soft drink consumption must be eliminated. If desired results are to be achieved, this is absolutely necessary. Continuing checkups and dental care from the patient's general dentist during the course of treatment is essential.

4. **Teeth may become non-vital.** This is always a possibility, with or without orthodontic treatment. Trauma from a blow, deep fillings, etc. may cause the nerve tissue in a tooth to die. This can happen over a long period of time. A pre-existing non-vital tooth, undetectable at the beginning of orthodontic treatment, may manifest itself through tooth movement and require additional treatment, most likely root canal therapy, in order to preserve the tooth or teeth.

5. **Root resorption:** In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease later in life the root resorption could reduce the longevity of the affected teeth. It should be noted that not all root resorption arises from orthodontic therapy. Trauma, impaction, endocrine disorders or idiopathic (unknown) reasons can also cause root resorption.

6. **There is also a risk that a problem may occur in the Temporomandibular Joints (TMJ).** Although this is rare it is a possibility. Tooth alignment or bite correction can improve related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of join pains. Although damage to the joint may have started long before the orthodontic treatment commenced, because of the subtle changes in the bite that occur though treatment, symptoms of this damage such as clicking, popping, crackling, pain, headaches, etc., may then become evident. Even though there were no apparent symptoms previously, these may begin to exhibit themselves during treatment.

7. **Shifting of teeth** might occur after orthodontic appliances (braces) are removed. Teeth have a tendency to rebound to their original positions after orthodontic treatment. This is called relapse. Very severe problems have a higher tendency to relapse more and the most common type of relapse occurs with twisted teeth. After braces removal, retainers will be placed to minimize relapse. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in many cases over correct in order to accommodate the rebound tendencies. Splinting teeth together with cement behind the teeth will help prevent relapse. I understand I am responsible for the retention phase of my treatment. We recommend retainer wear, at least part time for a period of years.

8. **Brush your teeth** and brackets thoroughly after each meal and before going to bed. Poor oral hygiene and /or improper brushing techniques can result in undesirable effects to teeth as well as surrounding tissue (puffy, bleeding gums, and white spots on teeth.) Failure to maintain good oral hygiene may cause permanent gum damage, inflammation and bleeding gums will delay your treatment.

9. **Professional dental cleaning** appointments should be made for every 6 months. While the braces themselves do not cause decay, they do collect food around them, increasing the chance for decay.

I understand that the main objective of my orthodontic treatment is to align my front teeth for cosmetic reasons. I understand that Dr. Baird is a general dentist who has had orthodontic training. My occlusion, or bite, and the relationship of my back teeth will not be change significantly. Significant changes in lip profile necessitate bone surgery which I am not seeking. I am aware of these objectives and limitations of short term treatment.

There is no guarantee as to completion within six month, but the majority of cases are treated within that time frame.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of orthodontic treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning any results from treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I accept all terms and conditions expressed within it and freely give my consent to authorize the Doctors of Cascade Family Dental in rendering services that they deems necessary or advisable for this subject orthodontic treatment.

Signature: ____ Date: ______________________