J. Orthodontics, Inc.

Informed Consent Form

FOR THE TREATMENT OF_____

(print patient's name)

The procedure(s) necessary to treat my orthodontic condition has been/will be explained to me by Dr. Samantha Jones and I understand the nature of the procedure(s) to be orthodontics customized to my needs.

IN THE VAST MAJORITY OF ORTHODONTIC CASES, SIGNIFICANT IMPROVEMENTS CAN BE ACHIEVED. WHILE THE BENEFITS OF A PLEASING SMILE AND HEALTHY TEETH ARE WIDELY APPRECIATED, ORTHODONTIC TREATMENT REMAINS AN ELECTIVE PROCEDURE. IT, LIKE ANY OTHER TREATMENT OF THE BODY, HAS INHERENT RISKS AND LIMITATIONS. THESE SELDOM PREVENT TREATMENT, BUT SHOULD BE CONSIDERED IN MAKING THE DECISION TO UNDERGO TREATMENT. POTENTIAL RISKS AND LIMITATIONS INCLUDE, BUT ARE NOT LIMITED TO:

MAJOR FACTORS WHICH LENGTHEN TREATMENT TIME AND ADVERSELY EFFECT THE QUALITY OF TREATMENT RESULTS

Lack of patient cooperation (most common factor), lack of or undesirable growth, insufficient wearing of elastics or headgear, broken appliances and missed appointments.

HEADGEAR- INSTRUCTIONS MUST BE FOLLOWED CAREFULLY

If pulled out while headgear is being worn, it can snap back and cause injury. Please wear as directed.

DECALCIFICATION- PERMANENT TOOTH DISCOLORATION

Good oral hygiene, reduction of sugar intake, and reporting any loose brackets or wires as soon as they are noticed will help minimize permanent staining, decay and gum problems.

NONVITAL OR DEAD TOOTH - TOOTH TRAUMATIZED BY A BLOW OR OTHER CAUSES

A traumatized tooth can die over a long period of time with or without orthodontic treatment. This may occur during orthodontic treatment and require a root canal.

IMPACTED TEETH- TEETH UNABLE TO ERUPT NORMALLY

In attempting to move impacted teeth, especially canines, various problems can be encountered which may lead to the loss of the tooth or periodontal problems.

ROOT RESORPTION- SHORTENING OF ROOT ENDS

This can occur with or without orthodontic treatment. Under healthy conditions, this usually is not a problem. However, trauma, impactions, endocrine disorders, or idiopathic reasons can cause this problem.

TEMPORMANDIBULAR JOINTS (TMJ) - SLIDING HINGE CONNECTING UPPER AND LOWER JAWS

Problems could occur at any time. Tooth position may be a factor in this condition. Clenching and grinding of teeth can also play a part.

GROWTH PATTERNS- FACIAL GROWTH DURING OR AFTER TREATMENT

Habits (ex. thumb sucking/tongue thrusting), unusual skeletal patterns and insufficient or undesirable growth can compromise dental results, affect a facial change and cause shifting of teeth during retention. Surgical procedures can frequently be used to counter these problems.

POST-TREATMENT TOOTH MOVEMENT - RELAPSE

During retention, teeth settle into position. Slight spaces in the extraction sites or between the upper central incisors are not uncommon. The major factor contributing to undesired tooth movement is the lack of cooperation in wearing retainers

SOME UNUSUAL OCCURRENCES ARE:

Swallowing appliances, chipping teeth, and dislodging or cracking restorations.

OTHER PROBLEMS:

I understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results.

ALTERNATIVES:

I have been/will be informed that there may be alternative procedures, treatments, or therapies to the procedure listed above, and I can discussed those with Dr. Jones.

UNDERLYING MEDICAL CONDITION AND MEDICATIONS:

I have informed Dr. Jones of any underlying medical conditions for which I am undergoing treatment and any medications I am taking.

PHOTOGRAPHS AND X-RAYS:

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of the same by the physicians and other health care providers involved in scientific papers and/or demonstrations. I

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I HAVE BEEN/WILL BE GIVEN AN OPPORTUNITY TO DISCUSS MY QUESTIONS REGARDING THE PROCEDURE(S) WITH DR. JONES.

I HEREBY AUTHORIZE DR. SAMANTHA JONES AND HER ASSISTANTS, AS MAY BE SELECTED, TO PERFORM THE PROCEDURE(S) pertaining to my treatment.

X_____

(patient, parent or legal guardian) Date

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Witnessed Date