Informed Consent for Orthodontic Treatment

As a general rule, informed and compliant patients experience positive outcome of orthodontic treatment. The benefits include improved dental health and enhanced facial and dental aesthetics. However, orthodontic treatment has limitations and incurs potential risks. While seldom of sufficient consequence to contraindicate orthodontic treatment, these risks and limitations should be considered in electing to undergo such treatment. Orthodontic treatment is, with rare exceptions, elective. As in all areas of the healing arts, results cannot be guaranteed, nor can all consequences be anticipated.

Risks and limitations.

1. Tooth decay, gum inflammation, bone loss, or permanent white markings (decalcification) of teeth may occur, particularly as a result of consumption of foods/drinks containing excessive sugar and/or inadequate oral hygiene maintenance.
2. Roots of teeth may be shortened during orthodontic treatment. Usually this is minimal and has no significant consequences. On rare occasions it may become a threat to the longevity, stability, and/or mobility of the teeth.
3. Teeth may have a tendency to change position after treatment. Proper use of retainers mitigates this risk. Throughout life the bite can change adversely due to eruption of wisdom teeth, unusual jaw growth pattern, maturational changes, mouth breathing, and/or oral habits — all of which are beyond control of the orthodontist.
4. Jaw joint (temporomandibular joint or TMJ) symptoms such as pain, headache, clicking/popping may occur during orthodontic treatment with no relationship to the treatment. Occurrence of such symptoms may require referral to a TMJ specialist.
5. Teeth that have been traumatized or that have large fillings may have undetectable damage to the internal nerve and blood vessels. Such pre-existing conditions may become acute during orthodontic treatment and in rare instances require root canal treatment.
6. Orthodontic appliances consist of interconnected small parts that may be accidentally swallowed or aspirated, or may irritate oral tissues. Cheeks and lips may be scratched or irritated by loose or broken parts or by trauma to the mouth or face. Patients may inadvertently get scratched or poked or receive superficial injury to a tooth with potential damage to, or soreness of, oral structures. Tooth tenderness of variable duration may occur following orthodontic appliance adjustment.
7. If improperly handled, headgear may cause injury to the face or eyes. Headgear is equipped with safety devices that minimize this risk. Patients are instructed not to wear headgear or other removable appliances while engaging in horseplay, sports or other vigorous physical activity.
8. Duration of treatment may exceed the estimate. Abnormal growth, poor cooperation in auxiliary appliance use, poor oral hygiene, broken appliances, missed appointments, and other factors may extend treatment duration and adversely affect outcome.
9. Orthodontic appliances are selected to achieve a specific therapeutic outcome. Design, construction, and material content may vary. Patients with allergies to component materials may elicit allergic reactions that require alteration or cessation of treatment with consequent limitation on quality of outcome. Although rare, medical management of dental material allergies may be required. Use of clear or tooth colored brackets, risks tooth attrition or tooth fracturing at bracket removal.
10. Adjunctive dental treatment may be required to accommodate to variable size, shape and number of teeth. General medical problems, such as bone, blood or endocrine disorders, can affect orthodontic treatment.

_____Initial

Acknowledgement of Informed Consent

I hereby acknowledge that Orthodontic Associates of Mercer Island, Drs. Kara McCulloch and Bill McNeill, further known in this document as **OAMI** have discussed, or will, discuss, major orthodontic treatment considerations, risks, and limitations with me. I have been, or will be, given the opportunity to ask questions about the proposed orthodontic treatment and have been asked, or will be asked, to make a choice about that treatment. I further acknowledge that I have read and understand this form.

Consent to undergo orthodontic treatment.
I hereby consent to the taking of diagnostic records, including x-rays, before, during, and following orthodontic treatment. I further consent to OAMI providing recommended orthodontic care.

Authorization for release of patient information.
I hereby authorize OAMI to provide other health care providers with information regarding the recommended orthodontic care. I understand that once released, the doctors have no responsibility for any further release by the individual receiving the information. I understand that OAMI will be sending a report along with radiographs and photographs to my dentist after my consultation. I hereby authorize OAMI to use my health information to obtain payment for services provided to me, or as required by law. My health information may also be disclosed to a friend or family member in the event of an emergency.

Consent to take x-rays.
Periodically panoramic and/or cephalometric/headfilm x-rays are updated to ensure that the roots of the teeth are positioned ideally, to survey for potential pathology, to assess growth, and to assess the position of unerupted teeth. Our x-rays are digital in nature and carry extremely low radiation dosage.

Consent to use records.
I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examination, treatment, and retention for purposes of professional consultation, research, education, or publication in professional journals.

Permission for release of photographs and/or video.
I hereby authorize the release of photographs and video with use of first name only for use on: Social Media sites of Orthodontic Associates of Mercer Island.

_____Initial

Information Disclosure.
I acknowledge that I have the right to submit written instructions to revoke or restrict certain uses and disclosures of information regarding orthodontic care. I also acknowledge that I can submit a written request to see and obtain a copy of orthodontic records. I understand that I can submit a written request to change any health information in those records. I understand that OAMI are not required to grant the request but that any request that is granted will result in the records being changed. The above information may be released by: Fax, Phone, Mail and Electronic Mail. My Consent is effective ***today*** and will continue ***indefinitely unless noted otherwise.***

I understand that my consent may be revoked at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in OAMI's Notice of Privacy Practices.

_____ _____
Patient name (**Please Print**) Patient or Guardian Signature Date

_____ _____
Witness (Print) Witness Signature Date