CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

CHRISTENSEN ORTHODONTICS
INFORMED CONSENT

The purpose of this memorandum is to inform the patient and/or parents of the course of events that they may expect during orthodontic treatment. It emphasizes the need for patient cooperation and points out the risks and limitations of orthodontic treatment. You are encouraged to read the following information, ask any questions that come to mind, and then consent to our treatment by initialing and signing this form. This is standard procedure in our practice.

1. TYPICAL ORTHODONTIC TREATMENT

_____ORTHODONTIC RECORDS

I hereby authorize Christensen Orthodontics to edit, copy, exhibit, publish and distribute any photo for purposes of publicizing or for any other lawful purpose, including the use of the photographs on the Christensen Orthodontics Facebook page or other social media sites. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein any likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photographs.

_____TREATMENT TIME

Orthodontics with full braces generally takes anywhere from one to two years. The insufficient wearing of elastics, removable appliances and headgear, broken appliances, poor patient cooperation, and missed appointments will result in extension of treatment and a compromise in the final result. If for any reason treatment is completed before the estimated time, the treatment plan fee does not change.

_____APPOINTMENTS

Depending on the stage of treatment, you may be required to visit the orthodontist every 8 weeks or as frequently as 3 times a month. Some appointments may require as little as 5 minutes, while others can be 2 hours or more. Your treatment will require a great amount of cooperation to accomplish treatment goals in the time prescribed.

_____RETENTION

After braces have been removed, you will be provided with clear, temporary retainers and either a fixed or removable retainer. Fixed retainers can require periodic maintenance which could include a charge. Removable retainers will be worn full time for the first year and then night time thereafter to ensure that the teeth hold and settle into their position. Failure to wear the retainers as prescribed may result in a partial relapse of the malocclusion and could result in the need for interventional treatment not included in original treatment estimate and cost.

MAILING RETAINERS: Should we need to mail you any of the clear trays, there will be a **$10 shipping fee.**

_____EXTRA COSTS/FEE's

DO NOT REMOVE any broken or loose appliances or fixed retainers. If for any reason any appliance or fixed retainer comes loose, contact the office immediately for an appointment. Removal of the appliance or fixed retainer can result in an additional charge. Fixed retainers are guaranteed for 12 months after the placement. If for any reason it comes loose or off after those 12 months, there is a **$92 REBOND CHARGE**, or possibly a replacement fee due at the time of service.

AFTER HOURS FEE: Should you need to be seen after regular office hours, there will be a **$92 FEE** due when the patient is seen.

NO SHOW FEE: Time is valuable for everyone. Please arrive on time for your appointment so we can ensure that all patients are in and out in a timely manner. If you are more than 10 minutes late for your appointment, you will be placed on stand-by, or asked to reschedule.
If you no-show your appointment, you will be charged a **$25 NO SHOW** fee. We require at least 24 hours' notice if you cannot make the appointment. Your first offense we will waive the fee as a courtesy. Your second offense will result in the $25 no show fee and payment will be required prior to the next visit. Your third offense will result in review of your account and you may be subject to possible non-treatment.

2. WHAT YOU CAN EXPECT DURING TREATMENT

_____DISCOMFORT

Orthodontics requires the use of wires to apply gentle pressure on the teeth in order to move them. When the pressure is applied, a tenderness of the teeth results. The teeth will remain sore for a period ranging from one to five days. The intensity and duration of the discomfort varies with each patient. If the pain is intolerable, possibly altering the method of straightening the teeth can decrease the discomfort.

_____ELASTICS

Elastics are used to help the orthodontist apply addition pressure to the teeth when needed. It is the patients' responsibility to follow the orthodontists' instructions regarding the use and wearing of elastics.

_____COOPERATION IS ESSENTIAL

Successful treatment can only be obtained with a team effort. In order to complete treatment, with the best results, and in the amount of time on your treatment plan, the patient must do the following:

- Keep appointments
- Practice good oral hygiene; clean your teeth and appliances after each meal.
- Wear elastics (rubber bands) as instructed.
- Inform office immediately of any broken, loose or lost appliances

FAILURE TO FOLLOW THE GUIDELINES, INCLUDING ANY INSTRUCTIONS FROM THE DOCTOR AT THIS PRACTICE, COULD RESULT IN ADDITIONAL COSTS.

_____EATING HABITS

You should not eat any hard, sticky or chewy foods, as these will tend to break or loosen your appliances. Apples, carrots and other hard foods must be cut up into bite-size pieces before eating. Chewing ice is prohibited. Your appliances can easily be broken if the above is not adhered to at all times.

____REMOVAL OF TEETH

No one likes to have teeth removed, but sometimes it is necessary in order to obtain the most desirable results. Having teeth pulled will be recommended as part of the treatment if it is determined that doing so will enhance the stability, esthetics and function of the final result.

_____GINGIVAL SURGERY

Gingival (gums) surgery may be required in order to place bands or brackets in the proper positions, to reduce tendency of relapse of severely rotated teeth, or to attach gingival, and for esthetic reasons. Should any of these procedures be indicated, it will discussed during the course of treatment.

_____FRENULOPLASTY SURGERY

A frenectomy may be diagnosed and recommended during or after orthodontic treatment. Frenectomy is a procedure to correct a congenital condition when the lingual (tongue) or labial (lip) frenulum is tight, resulting in restriction of function. If this procedure is needed further discussion will occur.

_____ORAL SURGERY

Some of the malocclusions are so severe that orthodontics alone cannot obtain adequate results; therefore, jaw surgery may be required in order to achieve acceptable and stable results. Should surgery be indicated, further discussion will occur.

3. POTENTIAL RISKS AND LIMITATIONS OF TREATMENT

_____DECALCIFICATION/DISCOLORATION

Orthodontic appliances do not cause tooth decay, but because of their presence, food particles are more readily retained and the potential for tooth decay is greatly increased. The reduction of sugar intake and reporting any loose bands will help minimize decay and gum problems. Patients should carry a toothbrush and clean their teeth and appliances after every meal. The permanent white lines that are seen on some teeth after braces are removed are called decalcification lines or spots. This is the result of inadequate oral hygiene.

_____SWOLLEN GINGIVA AND PERIODONTAL PROBLEMS

Periodontal disease can be caused by accumulation of plaque and debris around the teeth and gums. Regular and proper flossing and brushing can usually prevent swollen, inflamed, and bleeding gums. Also, systematic/unknown causes can lead to progressive loss of supporting bone and recession of the gums. Should this condition become uncontrollable, orthodontics may have to be discontinued short of completion. This is a rare occurrence that is usually found in adults with pre-existing problems.

_____ROOT RESORPBTION

Root resorption is a blunting of the root tips and occurs to a varying degree during all orthodontic treatment, but it is usually mild and does not affect the health or longevity of the teeth. The most common teeth affected are the upper and lower front teeth. X-rays will be taken to monitor the reaction of the roots during treatment. There are occasions when teeth spontaneously devitalize due to orthodontic treatment. If this occurs, root canal therapy will be needed for the continuation of treatment.

_____JAW PAIN/CLICKING

Jaw joint (TMJ) pain and clicking in the joints may occur anytime during one's lifetime. The symptoms of TMJ problems may express themselves in many ways, such as limited opening, popping or clicking sounds when the mouth is opened or closed. Multiple factors are usually the cause of this condition. It is more common in females in their late teens and early twenties and in the late forties. The emotional state of a person has a direct relationship to the severity of the joint pain. A less than ideal bite may be just one cause for this condition. Many dentists and other professionals s believe the TMJ problems are all bite related, but this is simply not so. Many TMJ problems cannot be solved by "fixing the bite", as they may be caused by abnormalities within the bite relationship, but orthodontics alone may not result in a reversal of the joint damage. If any of the above symptoms have been noticed, whether they were present before and stopped or are still present, it is important information for the orthodontist to know prior to the beginning of treatment.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I hereby acknowledge that the major treatment considerations and potential risks of orthodontic treatment have been presented to me. I have read and understand this form and also understand that there may be other problems that occur less frequently or are less severe, and that the actual results may be different from the anticipated results. Dr. Christensen has discussed the orthodontic treatment with me. I have been asked to make a choice about that treatment. I have been presented information to aid in the decision-making process, and I have been given the opportunity to ask Dr. Christensen all questions I have about the proposed orthodontic treatment and information contained in this form.

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment. I consent to orthodontic treatment for the above individual, by Dr. Christensen and his staff. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Dr. Christensen and staff to provide other healthcare providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, Dr. Christensen and staff have no responsibility for any further release by the individual receiving this information.

SURGICAL SUPPLEMENT

If the orthodontic treatment plan includes correction of the malocclusion by orthodontic appliance (braces) therapy in conjunction with orthognathic (corrective jaw) surgery, I understand that oral surgery is necessary in conjunction with the above patient's orthodontic treatment. I authorize Christensen Orthodontics to communicate with the surgeon and release information from the above patient's treatment record to the designated surgeon. I acknowledge that expenses incurred from the surgery are separate from orthodontic treatment expenses, and I will be responsible to the surgeon/hospital for all such expenses.

I understand that if I do not complete the surgical component of the treatment plan that I may have a compromised treatment result and other complications. I hereby agree not to hold Dr. Christensen and staff liable for any compromised treatment resulting from my failure for any reason to follow the treatment plan.

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Patient Name (Please Print)

_____ _____

Signature/Patient, Parent or Guardian Date