ORTHODONTIC TREATMENT (BRACES)-CONSENT FORM

Patient Name:
Age:
File number:
Chief complaint:
Treatment plan:
Treatment cost:
Date of Start:

I recognize the benefits of an orthodontic treatment to achieve a pleasing smile. I have been explained about all treatment options.

I understand that orthodontic treatment, like any other treatment of the body, has some inherent risks and limitations. Decalcification, decay, or gum disease can occur if i do not brush teeth properly during treatment period. I understand that a tooth that has been traumatized from a deep filling or a minor blow can die over a long period of time with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement, requiring endodontic (root canal) treatment to maintain it. I understand during treatment the root ends of the teeth may get resorbed minimally which may not cause any disadvantage. I understand if growth of jaws becomes disproportionate the original treatment objectives may have to be compromised. It may then require orthognathic surgery or prosthodontic intervention (with additional cost) to obtain a reasonable treatment result to complete the case. I understand that the total time for treatment can be delayed beyond the estimate.

Lack of, or poorly directed facial growth, poor elastic wear, or headgear co-operation, broken appliances and missed appointments are all important factors that could lengthen treatment time and it can also increase the total cost.

I understand that teeth have a tendency to return to their original position after orthodontic treatment (Relapse). A positioner or retainers has to be used as instructed to minimize relapse.

Special note

I have been explained about (Proximal slicing/Extractions/Expansion/Functional appliance/Mini implants/Orthognathic surgery) procedure for my orthodontic treatment.

I give my consent for the……procedure to be done when required during treatment.
or
I don't want to undergo……procedure and I have chosen to undergo camouflage treatment option. I understand that ideal occlusal results cannot be achieved with camouflage treatment.

……..
Signature of Patient/parent (Name & Relation)- **Copy Received**

……
Signature of witness

Date & Place

For Payment

1 In all kind of braces you will need to make 30 to 50 percent of advance payment, then onlt appliance will be fixed.

2 For Premium treatment like lingual braces , clear aligners 60 to 70 percent of total cost is to be deposited in advance , only then we place the order . it takes about 30 to 45 working days for orders to be delivered after payment. Appointment is scheduled after we receive the appliance.

3 Remaining balance of payment is to be made on treatment visits in instalments on as decided as per case. (Rs 2000-9000)

4 It is moral responsibility of patient /parent to make payment on treatment visit,we do not like to ask for making payments.

5 Any additional appliance if necessary for treatment will be charged separately. (expander, micro implants, lingual cribs etc)

6 Any breakages/debonding of brackests, tubes, accessory appliance is charged extra Rs 500-Rs 1000 (can vary/increase as per appliance)

7. We strictly advice the patient to follow diet instructions otherwise treatment will be delayed.

8 Each patient will be allotted a day and time slot for regular monthly visit. (Please convey your suitable day and time in beginning, please avoid to change the same.

9. Once in a while missing of appointment is understandable, but if it is noted to be routine due to which treatment is dragged. Then extra charges per visit (Rs 500-1500) will applicable.

Specific foods to be avoided- Hard ,Sticky and Fibrous foods-Chewing gums, Hard Candy, whole Apples, Hard Cookies,Tandoori Rotis ,Non veg food)

Don't even think of biting on pens and pencils.

Signature
Patient /Parent (NAME)

DATE

Place :