Georgia Orthodontic Care
Compassionate Heart . Outstanding Results

*Lawrenceville Office:* ***1605 Buford Dr., Lawrenceville, GA 30043*** *Norcross Office:* ***6040 Dawson Blvd, Ste C, Norcross, GA 30093*** ***(P) 678 985-8087*** ***Email: gaorthocare@yahoo.com***

# ORTHODONTIC TREATMENT CONTRACT

Patients Name: _____ Date: _____

This form explains what comprehensive orthodontics treatment is, what you can expect from orthodontic treatment, and what responsibilities you must assume as a patient or parent in order to make treatment a success. Included in this information packet is a document entitled "Informed Consent Factors in Orthodontic Treatment" which discusses risk factors potentially related to orthodontic treatment. Please read these materials carefully so you can ask question about anything discussed in the packet or about your specific treatment plan. Please be sure you understand what problems are to be corrected and what are not prior to beginning the orthodontic treatment. You will be asked to sign this form to show you have read the information and have had all questions answered to your satisfaction.

Diagnostic decisions have been made in determining what problems are present and how they may be corrected. To make these decisions, a set of diagnostic records which included plaster models of the teeth, selected radiographs of the head and teeth, photographs, and a medical and dental history were evaluated. After, evaluating the records, a plan of treatment was formulated to address the identified problems. The treatment planning conference provides an opportunity to discuss the specific problems present and the treatment planned to correct them. The estimated length of treatment and treatment costs are also discussed. The conference also provides an excellent opportunity for you to ask questions about the findings, the proposed treatment, possible alternatives, and orthodontics in general.

Comprehensive orthodontic treatment with full-fixed appliances (braces) usually provides the most ideal treatment for complicated orthodontic problems and generally provides the most stable results. On some occasions; adjunctive fixed or removable orthodontic appliances may be used in coordination with the braces to correct a specific associated problem as part of the comprehensive level of treatment is required to correct your occlusion and alignment problems. It has been determined more limited treatment options are not viable alternatives given the complexity of orthodontic problems presented by the diagnostic data.

**During your orthodontic treatment, it is imperative to maintain your routine visits to your regular dentist. It is the patient's responsibility to schedule a cleaning and cavity check every three-six months in order to maintain proper oral health. We reserve the right to remove your braces early if you do not follow proper oral hygiene instructions.** Poor brushing increases the risk of decay and decalcification when wearing braces. Excellent oral hygiene, reduction in sugar, being selective in diet, and reporting any loose bands as soon as noticed will help minimize decay, white spots (decalcification), and gum disease/problems.

In general terms, the comprehensive orthodontic treatment recommended will consist of:

_____
_____
_____
_____

The recommended treatment involves an estimated treatment time of _____ months to be followed by a structured retention period of _____ years.

The total fee for the comprehensive orthodontic treatment is $_____. The fee includes diagnostic records, treatment planning, appliances utilized during the course of treatment, regular and emergency visits, documentary progress records, and initial retainers. If appliances must be replaced due to loss, careless handling, or neglect, additional charges may be necessary to ensure optimal care. The orthodontic fee does not include any required restorative, oral surgery, or special dental services.

I certify that I have read and understand the contents of this consent form. I further realize the risks and limitations involved in the proposed orthodontic treatment. I am advised that though good results are expected the possibility and nature of complications cannot be fully anticipated and that there can be no expressed or implied guarantee as to the result of treatment or as to cure. Informed of these considerations, I hereby authorize and direct the performances of necessary orthodontic treatment or procedure(s) as described. I also authorize the use of diagnostic and treatment records for the purpose of teaching research and scientific publication.

_____ _____
Signature of Patient/Parent/Guardian Signature of Orthodontist/Group Name