Dental Treatment Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Orthodontic Care Consent

I, the undersigned, hereby grant my consent for the orthodontic treatment proposed by Dr. _____.

I understand that the treatment involves the following procedures:

- Initial consultation and examination
- Diagnostic records (x-rays, photographs, impressions)
- Placement of braces or aligners
- Regular follow-up appointments
- Possible extractions or other procedures as deemed necessary

I acknowledge that no guarantee can be made regarding the results of the treatment.

I have been informed about the possible risks and complications associated with orthodontic treatment, including but not limited to:

- Discomfort during and after placement
- Cavities and gum disease if hygiene is not maintained
- Relapse of teeth alignment after treatment

By signing below, I indicate that I have read and understood the information provided above and consent to proceed with the proposed orthodontic treatment.

Patient Signature: _____

Parent/Guardian Signature (if under 18): _____

Date: _____