2018
AAO ANNUAL SESSION
ORTHODONTIC STAFF PROGRAM

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COMMUNICATIONS REGARDING THE LEGAL AND ETHICAL ISSUES REGARDING DISMISSING PATIENTS & INFORMED CONSENT

AN INTEGRATED MANAGEMENT

RISK MANAGEMENT
PATIENT MANAGEMENT
PRACTICE MANAGEMENT
FISCAL MANAGEMENT

SEMINAR SERIES PRESENTATION

PROVIDING COMMON SENSE APPROACHES TO PRUDENT RISK MANAGEMENT IN CONTEMPORARY ORTHODONTIC PRACTICE

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NOTIFICATIONS

COMPLETION OF PHASE I

TO PARENT:

_____(pt's name)_____ has recently completed an important preliminary phase of orthodontic treatment. At the present time _____(pt's name)_____ will be followed on an observational basis to 1) allow for the continued development of the permanent dentition; and 2) evaluate the stability of the finished interim result

The second phase of orthodontic therapy for _____(pt's name)_____ will start when (his / her) teeth and skeletal growth are at their optimum stage of development. At that time, new records will be acquired and a new treatment plan developed to complete _____(pt's name)_____ orthodontic care. A new fee for this second phase of treatment will be charged at that time. If you have any questions in this regard, please feel free to contact us.

It has been a pleasure having _____(pt's name)_____ as a patient. If you have not already done so, now would be an excellent time to schedule a cleaning and exam with your dentist, please do so at your earliest convenience. I look forward to working with him/her in the near future as we continue providing _____(pt's name)_____ with the best possible dental care.

Sincerely

NOTE: **A similar version of this letter should also be sent to the patient's general dentist of record reminding him / her again that only Phase I therapy was performed and that comprehensive care will be initiated at the appropriate time.**

POOR COOPERATION LETTER TO PARENT / PATIENT

Dear: (Patient's Parent)

We are encountering problems with your child's cooperation which may result in achieving less than a desirable orthodontic result. The problems so far are:

[ ] not brushing teeth, gums and appliances as instructed.

[ ] not wearing rubber bands as required.

[ ] not wearing the Head Gear/ Night Brace / Face Mask the required amount of time.

[ ] not wearing or caring for the removable appliance(s) as instructed.

[ ] eating foods that break or loosen the appliances.

[ ] not keeping regularly scheduled appointments.

Patient cooperation is essential if we are to achieve the best result possible. Please see what you can do to address and rectify the above noted concerns. If you wish to discuss this matter with us, please feel free to call.

Respectfully,

NOTE: **A version of this letter should be sent to the patient's general dentist of record. It is important to keep him in the loop for a number of reasons. The two most common are that the GP often has a different relationship with the patient/parent and may provide additional support regarding amelioration of the non cooperative concerns. In addition, you don't ever want to be in the position where you have not advised the GP about the status of "his or her patient" not to mention the fact that treatment outcome may be adversely affected.**

If you choose not to use a version of this letter, use something like the status report on the following page.

PATIENT STATUS REPORT

To:
Date:
Re:

TREATMENT TIME:
[ ] progressing according to schedule
[ ] progressing ahead of schedule
[ ] progressing behind schedule
COMMENTS: _____

TREATMENT GOALS:
[ ] unchanged
[ ] altered treatment objective(s)
COMMENTS: _____

HYGIENE:
[ ] within normal limits
[ ] needs treatment
[ ] told patients to call your office
[ ] suggest you recall patient
COMMENTS: _____

COOPERATION LEVEL:
[ ] good [ ] average [ ] poor

COMMENTS: _____

UNIQUE FEATURES / GENERAL COMMENTS:_____

Respectfully,

WARNING AND DISMISSAL LETTER FOR NO-SHOWS

Dear:

We have not seen _____ since _____. **We have made several attempts to reschedule the necessary appointments, but so far we have been unsuccessful in this regard.** Obviously, we cannot assume any responsibility for problems that may occur if we are unable to treat (you / your child).

If we do not hear from you by _____we will assume that you / your child is no longer interested in continuing to receive orthodontic treatment at our office. In that event, we will remove _____ file from the roster of active patients whom we treat.

Please call us immediately so that we do not have to take this action.

Respectfully,

NOTE: **You need to start laying the foundation for dismissing a patient. Sending waning letters regarding the failure to keep regularly scheduled appointments is the first step in terminating the doctor patient relationship. The wording need not be exactly like what is written above but the idea must be the same.**

The same thought applies to the warning letter regarding delinquent accounts. Samples of this are seen on the next page. Again what you are trying to do is provide notice that if the situation is not fixed to the satisfaction of both parties, the patient's care will be terminated.

DELINQUENT ACCOUNT LETTERS
(KEEP DOCTORS AWAY FROM MONEY - DELEGATE TO STAFF)

DELINQUENT ACCOUNT LETTER - I
(USE WHEN MORE THAN 2 PAYMENTS BEHIND)

Dear (Financially Responsible Party) :

A periodic review of our patient accounts has just been completed. Our accountant advises us that your account is behind $_____.

IF THE ACCOUNT CONTINUES TO REMAIN IN ARREARS, WE WILL HAVE TO CONSIDER WITHDRAWING AS YOUR ORTHODONTIST OF RECORD.

Please remit the above amount in the enclosed envelope. If there is a problem meeting the payment schedule you designed, contact our office so that suitable arrangements can be made. If you feel that an error has been made, please let us know so we can correct our records.

Respectfully,

Bookkeeper or office manager

DELINQUENT ACCOUNT LETTER - II
(USE WHEN ACCOUNT IS DELINQUENT TOWARDS THE END OF TREATMENT)

Dear Financially Responsible Party :

(You or Patient's Name) have/has been scheduled to have his/her/your orthodontic appliances removed in the near future.

IT IS OUR OFFICE POLICY THAT ALL ACCOUNTS BE CURRENT PRIOR TO THE COMPLETION OF ACTIVE TREATMENT AND APPLIANCE REMOVAL.

Please contact the office to rectify this matter so that we can proceed with the removal of (You or Patient's Name's) orthodontic appliances at the scheduled time.

Respectfully,

Bookkeeper or Office Manager

DISMISSAL LETTER

Dear_____ :

Due to the fact that (choose from one or more of the six categories below) we must inform you that we are withdrawing from rendering further professional attendance to (your / your child's) orthodontic needs.

Since (her / his / your) dental condition requires further treatment, we urge that you seek continued orthodontic care and treatment with another orthodontist without delay.

If you wish, we will be available to attend to any orthodontic needs you may have for the next (30, 45, 60) days on an emergency basis only, to help you find another orthodontist, or with any other referral. If you need help in finding another orthodontist, please contact us in this regard. (If the patient calls, you can (1) give them the names of a few doctors in your area; (2) copy a page or two from the phone book or internet search; (3) give the patient the phone number of a local teaching hospital, clinic or school; (4) or, provide the patient with the number of the local dental society for their referral base).

Should you authorize the release of your / your child's orthodontic records, we will be happy to forward them to you or the orthodontist of your choice along with any other clinical information concerning the diagnosis and treatment rendered by us. (If you are charging a fee for duplicating records, state that here).

We regret having to take this action but the situation as noted above has left us no other option.

Respectfully,

1- there has been a lack of cooperation regarding following instructions which has been very detrimental to (your / your child's) dental health thus potentially compromising our ability to achieve an adequate orthodontic result,

2- We have not been able to agree on the goals for and/or the method of treatment for correction of your / your child's particular problem,

3- we are unable to coordinate the scheduling of appointments which in turn is jeopardizing (your / your child's) treatment; and, after repeated attempts have still been unable to do so,

4- you have not kept up with your financial obligations, under the terms that you agreed to, to pay for orthodontic services rendered,

5- you have not been honest and forthright in dealing with our office regarding the professional services rendered,

6- there are significant interpersonal differences and problems between (you / your child) and members of our office staff which have created disharmony and/or disruption to our daily office routine and activities

COMPLETION OF TREATMENT AND NEED FOR RETENTION

Dear

Active orthodontic treatment is now complete. Please be sure to preserve your investment of time, money, and effort in obtaining the benefits of orthodontic treatment by following these simple recommendations.

1- Make sure to schedule an appointment with your dentist as soon as possible. It is very important to maintain routine dental checkups.

2- Wear your retainers as recommended. A certain amount of settling of your teeth is normal. However, unwanted tooth movement will be minimized, if not prevented, by wearing your retainer as instructed.

3- If you have any questions or concerns, call us. We are committed to being an active participant of your oral health care team.

(If applicable, add the following paragraph):

As we discussed, there were certain limitations associated with your treatment. (State what they were in general terms) As previously noted, we do not expect you to encounter any problems of clinical significance from this. We will continue to monitor your orthodontic status during the retention phase of therapy.

We thank you for allowing us to provide the benefits that having orthodontic therapy can bring. We look forward to serving other members of your family, your friends, and the community at large. We hope you feel comfortable enough with our office, and the results you obtained, to recommend our services to others.

Sincerely,

NOTE: You want to let patients know that active treatment has been completed. If you have a formal retention schedule it should be noted somewhere in the subparagraphs above.

COMPLETION OF RETENTION

Dear:

The retention phase of therapy has now been completed. You no longer need to come to the office for treatment or follow up visits. If you desire for us to continue to monitor the stability of the finished result by providing follow up appointments, a “per visit” charge will be made for those services. As a reminder, we urge you to continue seeing your regular dentist for routine check ups. Preventive maintenance is essential for good dental and oral health.

Patients often ask, how permanent is my orthodontic correction? It has been the experience of orthodontists worldwide that most of the orthodontic correction achieved can be maintained over the long term. However, teeth are there to be used and some adaptive changes will occur. This is not a failure of the treatment rendered but is an example of the natural adaptation of your teeth to a changing environment. As your oral and facial muscles change over time, coupled with whatever oral habits you may have, and how your teeth and jaws function, all will determine your teeth’s natural environmental adaptation, and their ultimate position, as you mature through the aging process.

If you wish to ensure the most stable orthodontic results, life-time retention wear should be considered. If permanent retention has been recommended, it will now become the responsibility of your general dentist to monitor the integrity of the retainer.

Thank you once again for the confidence you have shown by choosing us to provide for your orthodontic needs. If we can be of other service to you, your family, or your friends, please let us know.

Sincerely

NOTE: **This is the formal goodbye letter and it is important because The doctor patient relationship is now over and the Statute of Limitations can commence to running (this will depend a great deal on which State you practice in and the applicable laws regarding tolling provisions). The point is you want the patient to have notice that treatment is completed.**

CONSENT AND

INFORMED CONSENT

NOTE: The laws regarding informed consent vary from State to State. Some States require that the doctor transmit information concerning the patient's diagnosis and treatment in accordance with what other reasonable practitioners would tell their patients under like circumstances. Other States require a practitioner to divulge any information that a reasonable patient may find material in determining whether to accept or reject the proposed treatment. The generic protocol listed below, was developed to be acceptable in most if not all States. The following is generally required to defeat claims for lack of informed consent.

INFORMED CONSENT

DIAGNOSIS: Should be transmitted in language that the patient or parent can comprehend; i.e: "you're bottom jaw is too far back"…NOT "you have a mandibular retrognathia" or "your overjet is 6 mm".

- The information can be transmitted in any medium.
  i.e.: video, booklet, consultation, etc.
- The information can be transmitted by any person.
  i.e.: the doctor, treatment coordinator, etc.

TREATMENT PLAN: Again, this information should be delivered in a plain understandable language.

- what you are going to do
- why you are doing it
- the length of time that treatment should take
- the fee for all services
- mechanotherapeutic approach to be employed
- required cooperation on the part of the patient

ALTERNATE TREATMENT PLANS:

- all viable treatment plans should be discussed, even if not practiced by you
- any necessary secondary treatment

RISKS, CONSEQUENCES, AND LIMITATIONS: Disclose to the patient, all probable risks, consequences and limitations for all treatment plans discussed.

- not every risk need be disclosed, only those that a reasonable patient might deem to be material in deciding whether or not to accept or deny treatment
- you only need to disclose just those that are probable consequences that might be encountered by an average patient, with this condition, undergoing this specific type of treatment.

PROGNOSIS AND EXPECTATIONS: Its just as important if not more so to tell the patient what your treatment cannot provide (limitations) in addition to the inherent benefits to be expected by undergoing treatment.

ALTERNATIVE OF NO TREATMENT: This is always an alternative and must be discussed along with the potential sequellae associated with this choice.

INFORMED CONSENT IS ONGOING IN NATURE: As the patient's clinical picture changes so does the need for a discussion of these findings and their potential effect on the patient.

How you go about obtaining a patient's informed consent should be memorialized in some fashion such as a patient's/parent's signature, noting in detail what information was disclosed to the patient. In addition, the patient should be given the opportunity to ask, and have answered, all of their questions.

NOTE: The following is a checklist that the person obtaining the informed consent from the patient/parent should use in determining the potential negative sequellae for each individual case. The items checked off should be discussed, and this discussion documented in some fashion.

CHECKLIST FOR INFORMED CONSENT REGARDING RISKS, COMPROMISES AND LIMITATIONS

[ ] HYGIENE RELATED PROBLEMS
- caries and/or decalcifications

[ ] ROOT RESORPTION
- does the root structure or intended mechanics predispose a greater risk of this occurring
- is there risk to an adjacent tooth i.e. an impacted canine and its effect on the root of the lateral

[ ] PERIODONTAL COMPLICATIONS
- will the intended mechanics heighten the potential for this sequellae
- is the patient's existing periodontal condition compromised or predisposing to negative sequellae

[ ] REBOUND AND/OR RELAPSE VS. NORMAL TOOTH MOVEMENT
- the natural phenomenon for teeth to respond to environmental factors should be discussed

[ ] TMJ/MPD
- the transitory and multifactoral nature of this potential problem should be discussed particularly if there are pre-treatment symptoms

[ ] ENDODONTIC PROBLEMS
- this should be discussed if there is a history of trauma, deep decay and/or restorations, or teeth that are out of or will be moved against or through the buccal plate or lingual cortex

[ ] ALLERGIES
- acrylic appliances, latex sensitivity, nickel

[ ] CERAMIC BRACKETS
- if using a chemical bond enhancing agent the patient should be informed regarding debonding fracture
- in addition, attrition and/or cusp fracture of the opposing dentition should be noted

[ ] REMOVABLE APPLIANCES
- ingestion, aspiration, and additional charges for lost or broken appliances

[ ] HEADGEAR
- the potential for soft tissue and/or ocular injury

[ ] ORAL SURGERY
- inability to close extraction spaces or osteotomy sites
- uncertainty related to the exposure of impacted teeth

[ ] GROWTH
- excessive, unanticipated, or insufficient growth can occur during or after treatment

[ ] INSUFFICIENT COOPERATION
- can extend the length of treatment
- can effect the amount of correction achieved
- if related to hygiene see above

[ ] SECONDARY RESTORATIVE TREATMENT NEEDED
- will the patient need implants, prosthetics, permanent splinting, etc.
- discuss that the fee for these secondary procedures is not part of the orthodontic fee charged

[ ] SKELETAL COMPONENT WITH ASSOCIATED DENTAL COMPENSATIONS
- if there is a skeletal component and camouflage therapy is recommended, discuss the anatomical limitations and the associated dental compensations that will remain at the end of treatment

[ ] RETENTION
- long term, lifetime, fixed or removable
- discuss with the patient that active treatment is completed and that the retention phase of treatment will last for "x" period of time
- discuss the prognosis for long term stability

[ ] LIMITED TREATMENT
- discuss the specific goals and objectives
- stop treatment when they have been met
- if a second phase of treatment will be necessary discuss that and that there will be a separate fee for that service

[ ] TOOTH SIZE/ARCH LENGTH DISCREPANCIES
- discuss the effect on the completed occlusal scheme
- discuss post treatment spacing
- discuss the need for post treatment restorative dentistry and that these fees are not part of the patient's orthodontic fee

[ ] CONTINUED DELETERIOUS HABITS
- if habits persist or develop post treatment, discuss the negative effect on stability

[ ] TIMING OF TREATMENT AND RELATED PROBLEMS
- discuss the option of 2 phases of treatment verses 1 phase
- be sure to include the fiscal, temporal, and psychosocial aspects of each

NOTE: **This form can either be used as a guide for the consultation visit or can be modified from checklist style to paragraph style to accommodate a patient's signature on the bottom or their initials next to each item, if desired.**

IMPORTANT INFORMATION ABOUT YOUR ORTHODONTIC TREATMENT

Orthodontic treatment like other forms of medical treatment offers tremendous benefits. Likewise, there are occasional problems that patients sometimes encounter. Most of the time these problems are usually not severe enough to contraindicate treatment, they should be considered by you before deciding to undergo orthodontic treatment. Please indicate your understanding of these facts by placing your initials in each box below.

DISCOMFORT: As your teeth move they may become slightly loose and this may be uncomfortable. Patients usually get used to this within a short period of time and once the braces are removed the teeth tighten up again. If you are having any pain – call your doctor, let us help. Also, your teeth may hurt for a day or two after an adjustment. This is normal and simple over-the-counter painkillers will be helpful. _____

ORAL HYGIENE: Properly brushing your teeth is a MUST. If proper oral hygiene is not maintained, permanent marks and scarring of the teeth can result. Poor brushing can also lead to cavities as well as to gum disease. In severe cases, treatment may have to stopped before it is completed or teeth may be lost. **You are responsible for continuing to see your regular dentist for check-ups and cleanings at least twice a year. Please don't expect us to replace your general dentist.** _____

ROOT DAMAGE: During tooth movement is not unusual for the tips of the roots of your teeth to shrink slightly. This is not significant unless it becomes severe. This may also occur as teeth are developing and erupting into the mouth. We will monitor your teeth throughout treatment and alert you to any significant changes. _____

TMJ / MPD: Sometimes during treatment, a patient's jaw joint will become inflamed. On rare occasions it becomes severe enough to require additional treatment by your dentist or other specialists. If you are having any problems – speak with your doctor. _____

RELAPSE: Change is everywhere and orthodontics is not immune. In children there are rapid periods of growth that cause dramatic changes in the size or jaw position of one's jaws. In adults, this change is merely the result of aging. Either way, orthodontic results are not 100% stabile and some movement is normal. We can't control genetics, habits, growth, the size of your teeth, and other factors that can cause teeth to shift slightly after treatment is completed. When treatment is complete, we will provide you with retainers which you will have to wear to help minimize this movement but nothing lasts forever, including straight teeth. _____

DAMAGE FROM APPLIANCES: Certain types of braces carry some associated risks. Ceramic braces may cause slight damage to the teeth they are attached to as well to the teeth they bite against. Patients have occasionally reported allergic reactions to the acrylic in their removable appliances, the latex used in the rubber bands, while others have had similar reactions to some of the metals used in traditional braces. Finally, there have been rare instances where a patient has suffered an eye injury because of improper headgear (night brace) use. _____

TREATMENT DECISIONS: Occasionally, patients have skeletal problems but are unwilling to undergo facial surgery to correct them. When this happens, certain compromises in the result have to be accepted. Similar compromises result when one chooses to only treat a limited aspect of a more involved problem. Braces are also often undertaken in preparation for other dental procedures that may not be followed through on. Finally, prolonging treatment can sometimes result in not being able to achieve the best correction. Decisions like these can cause a less than ideal result. ☐ _____

OTHER DENTAL TREATMENT: On rare occasions the nerve of a tooth undergoing orthodontic treatment will die and require a root canal. In addition, the inability to fully close an extraction space, or the loss of a tooth undergoing surgical exposure, are also rare side effects associated with those treatments. ☐ _____

ANATOMIC LIMITATIONS: Occasionally, a patient's teeth are not the correct size or shape for the size of the patient's jaw. This may result in slight spacing or the need for bonding or caps at the end of treatment. Also teeth can only be moved so far and if the jaws are too big or too small facial surgery may be necessary. ☐ _____

PATIENT COOPERATION: Patient cooperation such as following your doctor's instructions and keeping regularly scheduled appointments is absolutely necessary for optimal results to be achieved. If not, treatment time may have to be extended. Also, if patients continue to engage in harmful oral habits such as thumb sucking or grinding your teeth, the stability of the finished result may be compromised. ☐ _____

PATIENT PRIVACY: Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my treatment. Permission is hereby granted to exchange medical and dental information about me / my child only as it relates to providing and paying for orthodontic treatment. In addition, because treatment is being rendered at a teaching institution, I give permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations and for no other purpose. ☐ _____

OTHER: _____
_____
_____
_____
_____ ☐ _____

My orthodontic treatment has been thoroughly discussed with me. I have had the opportunity to ask questions about my proposed treatment and I understand the potential benefits and risks as noted above. I also understand that during treatment, circumstances may arise requiring either a discontinuation of or a change from the original treatment plan. If either of these occurs, it may result in adjustments to the cost of treatment. Lastly, I understand that the fee presented to me is only for orthodontic treatment and if other dental treatment is necessary, there will be additional fees charged for those services.

_____ _____
Signature of patient or parent if patient is a minor Date

_____ /_____
Signature and printed name of Witness

Note: The next series of letters is a unique and different way to handle informed consent. The "right to know" letter and the "how do braces work letter" should be sent to the patient before their first appointment. These are educational in nature. At the record appointment they are then given the "information concerning your treatment" letter which they should bring back with them when they return for the consultation visit. The returned letter can be signed or they can sign another copy at the consultation. Either way, the patient must be given time to develop and receive responses to any questions about the proposed treatment.

YOUR RIGHT TO KNOW

It's been said "an informed consumer is our best customer". This has never been more true than in the provision of health care services. What should you expect when you first visit an orthodontist? You should be told what the problem appears to be; what tests are necessary to properly diagnose the problem and formulate a treatment plan and; in the case of a child, whether now is the appropriate time to begin therapy or whether it's best to wait until a future date to initiate treatment. Let's look at these individually.

When a patient either desires to have or is informed that orthodontic therapy is recommended, he or she should be told why it is in their best interest to undergo such treatment. Some common reasons are: cosmetics (crooked teeth, overbite, etc.); to facilitate other necessary dental work (to properly position teeth for capping, bridges or implants); to correct a jaw discrepancy or skeletal disharmony (bite is off); or to help a patient maintain their periodontal status (health of the supporting gums and bone).

The next step is the gathering of necessary information by obtaining diagnostic records. The most often taken are: x-rays of the teeth to determine how sound they are and whether the bony support for them is adequate; a film of the skull to see the relationship of the teeth to the jaws and the jaws to one another; photographs of the face to assess one's profile and the effect that any proposed tooth or jaw movement may have on it; representations of the teeth (photographs or models) to help in determining the best approach for the treatment of your particular problem; a clinical exam to check for cavities and gum disease; and a review of your medical history as there are many underlying physical problems that can impact on the success or failure of orthodontic therapy. A consultation between the doctor or one of the office staff and the patient will then follow.

At the consultation your doctor should explain to you what the actual problem is in a language you can understand. You should be told why correction is advised and how it is to be achieved. You should also be informed of all reasonable alternative methods of resolving your particular problem. As

no form of medical treatment is without the potential for some risks, limitations, or compromises, you should be made aware of those that pertain to your specific situation. Next, you should be told what result you can expect from undergoing orthodontic therapy and finally, what will occur if no treatment is undertaken.

At this time the fee for the services to be rendered should be discussed in full and suitable financial arrangements made to the satisfaction of both you and your doctor. Make sure that you have had the chance to ask and have answered all questions regarding the proposed treatment plan, how long your treatment should take, and the financial responsibilities you are assuming. It is now time to begin treatment.

The appliances or braces will be specifically tailored to your particular problem. You may require removable and/or permanent appliances. Once they are attached to your teeth, make sure you have been given careful instructions on how to care for them. Check to be sure that your doctor will either be available or has made provisions for coverage if an emergency (breakage) arises. You need to be told that you have certain responsibilities to meet in order to achieve the best results possible. Some of these are: maintaining good oral hygiene, wearing rubber bands, a headgear, or other auxiliary appliances as instructed, keeping your regularly scheduled appointments, etc. You must also continue to see your general dentist at least twice a year unless your orthodontist recommends otherwise.

At the completion of active treatment you will undergo a period of retention care. This phase of treatment is necessary to evaluate and help maintain the results achieved. An appropriate retainer will be fabricated to maximize the stability of the finished result. Remember, nothing lasts forever and some movement of your teeth over the years is normal and to be expected.

Orthodontic therapy carries many benefits. Evaluating these can only be done if you have been given sufficient information on which to base your decision to undergo care. You have a right to know and to be educated as these tools enable you to choose wisely.

HOW DO BRACES WORK

Braces, also called orthodontic appliances, are mechanical devices that when attached to the teeth permit specific forces to be transmitted to the teeth, which in turn causes them to move. Braces come in many different designs, the two most common are removable and fixed.

Removable braces are often called retainers, spring aligners, bite plates or functionals; all of them serving different purposes. Some function to keep the jaws apart during tooth movement; others actually reposition the jaws to some extent allowing the orthodontist to attempt to modify jaw growth. Many have the ability to move teeth but they lack the same precision that occurs when fixed appliances are used. Finally, removable appliances are most often used to help stabilize the finished orthodontic result. Depending upon the purpose for which they are employed, these types of braces need to be worn anywhere from full to part time. Your orthodontist will give you specific instructions regarding when to wear and how to care for them.

Fixed appliances are comprised of two parts. The part that attaches to the tooth is either called a band or a bracket. Both bands and brackets have specifically designed attachments known as tubes or brackets so that the second part, the wire, can be secured to the fixed appliance. Bands are made of metal but brackets can be made from either clear or tooth colored plastic, ceramic material, porcelain, as well as metal. The bands are cemented around the teeth while brackets are bonded by various methods to a small part of the tooth's surface. The materials used for cementing or bonding have certain properties that make it relatively easy to remove the braces after orthodontic therapy is completed.

The wire has two functions. By virtue of its shape, or by your doctor placing certain bends into it, the wire has the ability to move your teeth in a desired direction. Because of the type of metal employed, the process used in manufacturing, and the size of the wire; very specific forces can be applied to the teeth. Thus, the wire has the potential to precisely move the teeth according to your doctor's treatment plan. The second function of a wire is to act as a track for the teeth to move along. When used for this purpose, tooth movement is accomplished by using different springs or elastics with varying force levels. Again, detailed control is the main feature of the fixed appliance. Returning for periodic visits to adjust the force levels used, and by carefully monitoring the progress achieved, orthodontic correction occurs.

At the cellular level, when orthodontic forces are applied to a tooth a corresponding force is transmitted to the underlying bone. Certain types of cells respond by softening the bone on the "pressure" side while other cells lay down new bone on the "tension" side as the tooth moves in the desired direction. It is important to understand that tooth movement should be a smooth, uninterrupted process if the best results are to occur. For this to happen your doctor will often depend on you to help effect the desired changes. This will occur through your cooperation with such things as keeping regularly scheduled appointments, wearing and changing rubber bands as instructed, using a headgear in a certain way, being careful not to break or bend the fixed appliances, and keeping your teeth and gums clean and healthy.

A successful outcome is not achieved by chance. It is the result of continued education on the part of your doctor; technical excellence by all members of the orthodontic team; stringent cooperation on the part of the patient; and last but not least, patience. It takes time for your teeth and their surrounding structures to change from a malocclusion into a beautiful smile.

If you have any questions, call your orthodontist. Don't have one? Call us.

INFORMATION CONCERNING YOUR TREATMENT

The following paragraphs are meant to advise you that occasionally, during orthodontic therapy, some patients may encounter minor problems. While this should not deter you from seeking care, it is important to allow you, the patient, to evaluate the benefits of orthodontic therapy against the potential risks that accompany all forms of medical and/or dental treatment.

ORAL HYGIENE:

If a patient does not maintain good oral hygiene then cavities, permanent scarring of the teeth, or significant periodontal breakdown of the supporting gum and bone can result. Properly brushing, flossing and keeping the braces clean will help avoid this problem. Regular visits at least twice a year to your dentist are a must, and can also negate or minimize these risks.

ROOT RESORPTION:

This is a condition where during treatment the roots of some of your teeth may start to shrink, thus providing less support for them. If this occurs, it is usually minimal and not a problem unless it becomes severe. While significant root resorption is rare, if it starts to occur, it may be necessary to prematurely discontinue treatment thereby preserving the tooth or teeth in question.

RELAPSE:

Nothing lasts forever. This also applies to the orthodontic results that are achieved. Orthodontic therapy is undertaken to improve your overall oral health and to make your bite as normal as possible given the clinical circumstances. There are many factors your doctor cannot control such as:

- the direction and amount of growth remaining in your jaws,
- the size and relationship of your jaws to each other and to the rest of your face,
- the soft tissue and bony support for your teeth,
- the size and shape of your teeth and fillings,
- oral habits such as chewing on pens, playing musical instruments, etc.,
- the presence and position of wisdom teeth, and
- the patient's cooperation during treatment.

All of these factors have the potential to affect the stability of the finished orthodontic result. Finally, remember that all of the tissues in the body change with the aging process; the position of your teeth is no different.

TEMPOROMANDIBULAR DYSFUNCTION (TMD):

You may experience problems with your jaw joint during or after treatment. It is easy to blame orthodontic treatment as the cause; however, in the overwhelming majority of situations such is not the case. The fact is that orthodontic therapy is often undertaken in an attempt to correct a temporomandibular problem. If this problem should occur, and persist, further treatment by a specialist in this area may be necessary.

OTHER POTENTIAL RISKS:

Finally, some orthodontic appliances may have risks associated with them such as:

- headgear (nightbrace) which if not worn properly has been known to cause soft tissue injury to the face or eyes;
- ceramic and porcelain braces have been known to be associated with excessive tooth wear and/or fracture of the tooth they are attached to or to the opposing teeth;
- allergic reactions to some of the bio-materials used during treatment have occurred on very rare occasions; and
- the possibility of swallowing or aspirating a small piece of one's brace.

SUMMARY:

The above noted information is necessary in order for you, an informed consumer, to better appreciate that all medical treatment, including orthodontics, carries some small downside risks. Fortunately these risks are minimal, rarely happen, and can be easily dealt with should they occur. The tremendous benefits associated with orthodontic therapy usually far outweigh any potential negative occurrences associated with treatment.

We encourage you to ask questions of us before, during and after treatment so that you become one of our most important assets... a happy and informed orthodontic consumer.

_____(Patient or Parent's Signature)_____ ___(Date)

CONSENT FOR USE OF TAD's
TEMPORARY ANCHORAGE DEVICES

Your doctor has recommended the use of a temporary anchorage device (TAD) also known as a micro screw or mini screw. This device is to aid your doctor in his ability to move certain teeth while not affecting the position of other teeth. While this is not the only method to achieve the desired result, it is a very effective and efficient means of doing so, but it does carry some risks of which you should be aware. The following paragraphs are designed to inform you of the known risks associated with this procedure thereby providing you with sufficient information to make an informed decision about accepting this form of treatment.

PLEASE PLACE YOUR INITIALS IN THE BOX NEXT TO EACH PARAGRAPH INDICATING THAT YOU HAVE READ AND UNDERSTOOD WHAT IT SAYS.

ALTERNATIVE TYPES OF TREATMENT

The TAD procedure has been explained to me and I understand that it is one of several alternative means to achieve a desired result. The other anchorage alternatives along with any compromises and limitations associated with them has been explained to me. _____

PAIN AND / OR DISCOMFORT

Any surgical procedure carries the risk of some degree of pain or discomfort. Inserting a TAD is no different, however any pain or discomfort can usually be addressed through the use of simple over the counter pain medication. There is usually no problem with returning to work or school the next day. If you are still experiencing significant discomfort after 48 hours, call your doctor immediately. _____

INJURY TO THE ROOTS OF TEETH

As TAD's are placed in close proximity to the roots of your teeth, the implants may occasionally come into contact with them. While this may cause minor damage to the roots, in most cases this type of injury is not clinically significant. On rare occasions a root canal procedure may be required. It is also remotely possible for TAD placement to result in loss of a tooth. _____

BLEEDING AND / OR POST OPERATIVE INFECTIONS

All surgical procedures carry the risk of excessive bleeding or post operative infection. While the potential for excessive bleeding is extremely rare, occasionally a minor infection may result from the placement of a TAD. Should this occur, routine antibiotic therapy may be necessary. _____

INJURY TO THE NERVES

Placing a TAD may injure a nerve leading to a tooth or to the jaw. The resulting tingling and / or numbness is usually temporary but on rare occasions it may become permanent. _____

PERFORATION OF THE SINUS

Occasionally, a portion of the TAD may perforate the sinus. Usually this does not present a problem. On rare occasions, if a perforation does not heal properly, a second surgical procedure by another doctor may be necessary to repair the sinus. _____

REMOVAL OF IMPLANT / CHANGE OF TREATMENT PLAN

All TAD's need to be removed after your treatment is completed. However, if one or more TAD's should have to be removed early because of any of the above noted factors, even at the time they are placed, your treatment plan may have to be changed. It may be as simple as using another form of anchorage, having to extract teeth, or, in rare situations, jaw surgery may be required. Your doctor will discuss these options with you if the need arises.

_____

PATIENT COOPERATION

Patient cooperation such as following your doctor's instructions regarding the wearing and changing of any elastics, as well as following precisely any oral hygiene instructions, is critically important to minimize negative occurrences and maximize the results of therapy.

_____

OTHER FEES

I understand that the fee presented to me is only for orthodontic treatment including the placement of the TAD's. If other dental or surgical treatment is necessary, there will be additional fees charged for those services by the doctors who provide those services.

_____

PATIENT PRIVACY

Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my treatment. Permission is hereby granted to exchange medical and dental information about me / my child only as it relates to providing and paying for my treatment. In addition, I give permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations and for no other purpose.

_____

GUARANTEES

I understand that perfect results are not guaranteed in the delivery of oral health care services and that the use of TAD's as part of my treatment will neither guarantee a better result nor faster treatment.

_____

MY UNDERSTANDING

I certify that I speak, read, and write English or, have had the contents of this form translated to me in my native language. I fully understand the benefits and risks associated with using TAD's and voluntarily accept them.

_____

Printed name of patient or parent (if a minor)	Signature of patient or parent (if a minor)	Date
Printed name of witness	Signature of witness	Date

INFORMED CONSENT REGARDING INTERPROXIMAL REDUCTION

You have been advised that as part of your orthodontic treatment plan, it is necessary to remove some enamel from the sides of some of your teeth. This procedure goes by various names. It is often referred to as interproximal reduction, reproximation, stripping, IPR, and enamelplasty.

WHAT IS INTERPROXIMAL REDUCTION (IPR)?

Essentially, what the procedure involves is removing small amounts of enamel from the sides of one or more teeth in an effort to make a tooth's dimension smaller. This is most often done to create additional space to resolve mild to moderate crowding as well as to recreate normal anatomy for a tooth that was slightly malformed. Other alternative methods to create this space would be to either extract permanent teeth or to flare out the teeth and expand the dental arch form, each one of which has its own potential negative consequences.

HOW IS IPR PERFORMED?

There are two basic approaches to removing enamel from the sides of teeth. The first is to take "sandpaper" like strips and rub them back and forth along the sides of the teeth removing a small amount of the outer layer of enamel. The other most common way is to use rotary instruments (dental drills) with either very thin discs or very small burrs to file down the sides of the teeth.

WHAT ARE THE RISKS OF THIS PROCEDURE?

For the most part, the risks are very small. Occasionally however, the following occurrences sometimes happen:

- small step like projections can occur along the side of a tooth,
- cavities may occur in areas where the tooth has been filed down,
- the affected tooth may become sensitive to hot or cold stimulation,
- the gum tissue around the tooth may become cut, inflamed or swollen,
- the shape of the affected teeth may be different from the adjacent teeth, and
- the patient's gums, lips or tongue may be cut during the procedure.

While the above occurrences do sometimes occur, when they do most of the time they are of such a minor nature that there are no long lasting negative effects. In very rare cases, IPR may lead to the nerve of a tooth being permanently injured.

DO I HAVE TO HAVE THIS PROCEDURE PERFORMED?

No you do not, but as previously mention, the only other alternatives would be to extract permanent teeth or to place the teeth in positions that might be very unstable.

CONSENT

I have been informed that [ ] I [ ] my child requires IPR and I acknowledge that I am aware of what the procedure is, what it entails, and the potential risks associated with the procedure. I have also been informed about other alternatives to IPR. I have had the opportunity to have all of my questions concerning IPR asked and answered.

_____ _____

patient, parent, or legal guardian date

CONSENT FOR LIMITED TREATMENT

Orthodontics provides you with the opportunity to improve certain aspects of not only how your mouth functions but also, how your smile looks. Generally speaking when patients go to an orthodontist for a consultation, they are presented with the best treatment plan that addresses all of the patient's complaints as well as the doctor's concerns. Occasionally however, orthodontists find that their patients desire to only have limited treatment performed.

For example, let's say that you have some crooked or crowded upper front teeth. You also have an overbite with your top teeth sticking out a little bit past your lower front teeth. Your doctor may want to fix the overbite as well as the crowding in one of a number of different ways. You on the other hand, don't care about the overbite and merely want your front teeth aligned to improve your smile.

Enter the world of limited treatment. If you decide you only want to correct part of your total orthodontic problem, that's fine; however you must be aware of certain facts.

1- Deciding to accept limited treatment means just that. Your doctor will only address those concerns. Other orthodontic problems will not be corrected.

2- If, after correcting what you were concerned about, you now choose to have the remaining problems addressed, an additional fee will be charged and additional time in braces will be necessary.

3- We will not offer a patient the limited treatment option if the patient's periodontal support cannot withstand the rigors of orthodontic tooth movement OR, if in our opinion, limited treatment will cause other harm to the supporting hard and/or soft tissues in your mouth.

4- In some cases the ideal result cannot be achieved because we are not treating all of the teeth. This is a limitation YOU, the patient, must accept.

5- Limited treatment results must be maintained after treatment is completed in the same way that full orthodontic therapy must be retained. Your doctor will explain the necessary retention protocol to follow.

6- Over time, there may be detrimental effects from not having comprehensive or full treatment performed. Remember this would have happened anyway had you chosen not to have any treatment; and it may still occur even though you had limited treatment, as the cause may have been the problem(s) you chose not to treat.

++

I, _____, have had the option of limited treatment explained to me and understand that only a portion of my orthodontic problem(s) will be addressed. The choice to accept limited treatment is mine alone and I am aware of the limited benefits to be achieved. I understand and release Dr. _____ for any negative occurrence I may encounter as a result of allowing only limited treatment to be performed.

_____ _____

signature of patient / parent date

_____ _____

signature of witness date

INFORMED CONSENT REGARDING LASER THERAPY

You have been advised that as part of your orthodontic treatment plan, it is necessary to use a soft tissue dental laser to expedite a particular aspect of your treatment. This form will explain why we are recommending this procedure, any risks commonly associated with this procedure, as well as alternative therapies that exist.

WHAT IS LASER THERAPY?

Essentially, what the procedure involves is using a laser beam to remove small amounts of gum tissue from around certain parts of your teeth. This is most often done to address the following situations:

1- One or more of your teeth is through the bone but has not yet erupted through the overlying gum tissue. Often, because the tooth in question is in the wrong position, it is important to be able to attach a brace to it to a) direct it to the proper position or b) to prevent it from moving into a worse position. If it has not erupted into the mouth yet, this is impossible to do. The laser beam will remove the tissue covering the tooth and allow us to put an attachment on it thus expediting your treatment.

2- Sometimes a tooth is in the mouth but there is still some gum tissue covering it that is preventing us from putting a brace on the proper spot on the tooth. In this situation we need to remove some of the overlying gum tissue so we can help to insure that we are able to move the tooth as we want to.

3- If a patient's brushing is not good, occasionally the gums can get puffy and overgrow the teeth. When this happens the excess gum tissue needs to be removed to help minimize the chance of the gum disease getting worse or cavities forming along the gum line.

4- There are other less common reasons for using a laser in orthodontics and these will be explained to you if they occur.

HOW IS LASER THERAPY PERFORMED?

The first thing we do is to make sure that you are comfortable so we will give you a little local anesthetic to numb the area. Then everybody in the room where the procedure is performed will put on safety glasses to protect their eyes from the laser beam. We will then use the laser to remove the little bits of overlying gum tissue so your orthodontic treatment can move along in a timely manner. Sometimes there is a slight odor that comes from removing the tissue but this goes away after the procedure is completed. It may look like the gum edges have been burned but this appearance goes away within a day or two. You are able to brush and eat after a short time. Your doctor will give you specific instructions about this.

WHAT ARE THE RISKS OF THIS PROCEDURE?

For the most part, the risks are very small. Occasionally however, the following occurrences sometimes happen:

- if you have had a problem in the past with local anesthetics, please let us know so we can prevent it from happening again
- if you are taking certain prescription and non prescription drugs your healing may be effected, be sure to inform the doctor of all medications you are taking
- if you smoke it will have a negative effect on your ability to heal properly
- if you have any underlying health problems such diabetes, please let your doctor know as it can effect healing
- sometimes a patient's gums feel like they eaten a piece of pizza that is too hot and they suffer a slight burn which goes away in a couple of days

DO I HAVE TO HAVE THIS PROCEDURE PERFORMED?

No you do not, however the only other alternatives would be to do nothing and possibly allow the situation to get worse or to use different surgical method to expose the tooth. This other type of surgery may carry the risks of excessive bleeding, infection and more difficult or longer healing process.

CONSENT

I have been informed that [ ] I [ ] my child requires soft tissue laser therapy and I acknowledge that I am aware of what the procedure is, what it entails, and the potential risks associated with the procedure. I have also been informed about other alternatives to this procedure. I have had the opportunity to have all of my questions concerning laser therapy asked and answered.

_____ _____

patient, parent, or legal guardian date

RELEASE FROM LIABILITY FOR REMOVAL
OF ORTHODONTIC APPLIANCES AGAINST MEDICAL ADVICE

This is to certify that I, ____(Parent's or Patient's name)____, voluntarily request the removal of [my / my child's] (Insert patient's name if a minor) orthodontic appliances and the termination of my / his / her orthodontic treatment.

I have been informed that [my / my child's] orthodontic treatment is not completed and that ___(Doctor's name*)___ strongly recommends the continuation of treatment in order to obtain the best possible result. In addition, I have been informed of and I understand the probable negative consequences that may occur as a result of my discontinuing treatment before it is completed and against the advice of _____(Doctor's Name*)___.

I hereby release ____(Doctor's name*)____ from any responsibility and for any and all injuries or damages that I may suffer both presently and in the future as a result of my decision to terminate my / my child's treatment against the sound medical advice of my orthodontist.

Signature of Patient	Date	Witness	Date

*** NOTE:** **If Dr. is a professional corporation, partnership, LLC, etc. or has any associate doctors providing treatment in the office, place the name of the business entity, the names of everyone who treated the patient as well as the Doctor's personal name in this space.**

Patient's Name: _____ **Date:** _____

THE FOLLOWING RELEASES MUST BE SIGNED BEFORE ANY PATIENT CAN RECEIVE ORTHODONTIC TREATMENT

RECORDS RELEASE - OUTGOING

I understand that the orthodontic records of me / my child may be requested by other doctors, insurance companies, Medicaid, etc. I therefore give my permission for (Insert Doctor's Name and Name of Office) to make available any orthodontic record(s) of me / my child's in order to facilitate treatment, payment of financial obligations, etc.

_____ _____
Signature of patient or parent/guardian if under 18 Date

PHOTOGRAPHIC RELEASE

Until stated otherwise, I give my permission for (Insert Doctor's Name and Name of Office) to use any or all of my orthodontic records (models of teeth, x-rays, photographs, etc.) of me / my child for use in scientific articles and / or lectures. This permission is granted for these specific purposes only and not for any other use.

_____ _____
Signature of patient or parent/guardian if under 18 Date

RECORDS RELEASE - INCOMING

I hereby permit any health care practitioner who has treated me / my child to transfer any and all medical and dental information on file to (Insert doctor's name, or practice name and address);

_____ _____
Signature of patient or parent/guardian if under 18 Date

CHILD CARE RELEASE

I am aware that (Insert Doctor's name and name of Practice) cannot and will not assume any responsibility for the care or oversight of any minor, patient or otherwise, left unattended prior to, and/or after their treatment visit has been completed. In addition, we will not undertake to monitor the behavior of or care for small children left unattended in the waiting room while their parents are in the treatment area.

_____ _____
Signature of patient or parent/guardian if under 18 Date

PERMISSION ALLOWING INTERNET TRANSMISSION OF PROTECTED HEALTH INFORMATION

Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my orthodontic treatment. These consultations often involve sending my clinical information and other protected health information over the internet. In order to expedite my treatment and facilitate my care, permission is hereby granted to my doctor to use the internet to effectively exchange any and all medical and dental information about me / my child with other doctors he has chosen to consult with but only as it relates to providing my / my child's orthodontic treatment.

In addition, I give my permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations, for purposes of maintaining licensure or specialty certification, or for complying with duly authorized administrative requests and for no other purpose.

_____

Signature of patient / parent & Date

NON-DISPARAGEMENT CONTRACT

In exchange for a fee reduction of $_____ from the usual and customary fee charged by Dr. Goode for his orthodontic services, I am voluntarily agreeing to be bound by the terms as specified below.

In an effort to ensure that all public feedback or commentary regarding the orthodontic services provided by Dr. Goode's office is both fair and honest, and to prevent the publishing of libelous content in any form, you agree that you will not, nor will you cause or cooperate with others to, publicly criticize, ridicule, disparage, or defame Dr Straightensem Goode, his professional corporation, employees, contractors, and associates, with or through any written or oral statements or images including, but not limited to, any statements made via Web sites, blogs, postings to the Internet, or e-mails, whether or not they are made in your name, anonymously, or with a pseudonym. You also agree to provide full cooperation and assistance in aiding this office or its representatives to investigate such statements if we reasonably believe that you are the source of the statements. The foregoing does not apply to statutorily privileged statements made to governmental or law-enforcement agencies, nor does it apply to statements made or testimony given during the course of any duly filed litigation in courts of competent jurisdiction between you and this office.

If you violate this clause, as determined by Dr Goode in his sole discretion, you will be given a 72-hour opportunity to retract the content in question. If the content remains, in whole or in part, you will immediately be indebted to Dr Goode for the amount of $100,000 for liquidated damages. Since actual damages would be difficult to determine as a result the disparagement, this agreed-upon amount represents a fair and reasonable estimate by both parties of the financial loss that negative posts will cause. This amount was determined to be a reasonable estimate by assuming that 20 patients during a year, at an average fee of $5000, will not seek treatment from Dr Goode as a result of the disparagement. This agreed-to amount is not deemed to be punitive but, rather, a fair representation of future damages. In addition, if you decide to litigate this matter and if you are found to be liable for having breached the nondisclosure agreement, you also agree to pay all of Dr Goode's reasonable attorney's fees as well as court costs relating to the litigation. If these charges remain unpaid for 30 calendar days from the billing date, your unpaid balance will be subject to collection and all other legal remedies available. In addition, the debt will be reported to all appropriate consumer credit reporting agencies until paid. Finally, the parties agree and acknowledge that this provision is a material term of the doctor-patient contract, the absence of which would have resulted in Dr. Goode refusing to render orthodontic treatment to you / your child.

_____ _____

PATIENT OR PATIENT'S PARENT/GUARDIAN DATE

_____

DOCTOR OR DOCTOR'S REPRESENTATIVE

RELEASE FROM LIABILITY

This agreement between [(Parent's Name) as legal guardian for (Patient's Name)] or [(Patient's Name)] and (Doctor's Name*) is being executed to resolve a disagreement regarding orthodontic services rendered. All parties agree that the signing of this document does not imply nor constitute an admission of liability on the part of (Doctor's. Name*), or his/her partners, employees, agents, or contractors.

In consideration of $_____ paid by (Doctor's Name*) to (Patient or Parent's Name) ; (Patient's Name), his/her heirs, executors, administrators, assigns, and/or guardians hereby fully releases (Doctor's Name), his/her employees, agents, contractors (if you employ an independent contractor include that Doctor's name here), partners (include the name(s) of any partner(s) here), and his/her professional corporation from all claims and causes of action stemming from any injury previously suffered, presently sustained, or one that may cause to be suffered in the future as a result of the orthodontic treatment rendered between (dates of treatment).

I (Name of person signing) have read and fully comprehend all of the foregoing agreement. I also understand the rights I am waiving. I have had the opportunity to consult with an attorney on this matter, and freely agree to the terms and conditions set forth in this agreement dated this ____ day of _____ 201 ___ .

(Signature of Patient or Legal Guardian)

(Signature of Witness)
(print name and address of witness)

*If Dr. is a Professional Corporation or LLC, list both the corporate and individual names.

RELEASE FROM LIABILITY FOR REFUSING X-RAYS

I (Patient/ parent's name) have been informed by (Doctor's name*) that x-rays are an integral and important diagnostic aid that is used in order to render high quality dental care. I fully understand the importance of taking dental x-rays and yet refuse to have them taken. Because of my refusal, optimal care may be compromised or not achieved. I therefore accept complete responsibility for any of the following consequences occurring as a result of my refusal to have x-rays taken, an action that is against the advice of my doctor.

- Undiagnosed decay between the teeth, around and underneath existing fillings, or around and underneath the gum line.
- Periodontal disease and loss of supporting bone.
- Impacted or unerupted teeth and their ramifications.
- Cysts of all types: benign, malignant and potentially malignant.
- Root fragments remaining.
- Extra or missing teeth and their ramifications.
- Abscesses (infections) and their ramifications.
- Fractured teeth or jaws.
- Tumors or cancerous lesions.
- Root resorption and subsequent loss of teeth.
- Other unspecified disease which can only be diagnosed by utilizing x-rays or which can be diagnosed early through the use of dental x-rays.

In view of the above I hereby release (Doctor's name*) from all claims or causes of action stemming from any injury previously suffered, presently sustained, or one that may cause to be suffered in the future by me / my child as a result of my refusal to allow recommended diagnostic x-rays to be taken.

(Signature of Patient or Legal Guardian) (Signature of Witness)
(print name and address of witness)

*If Dr. is a Professional Corporation or LLC, list both the corporate and individual names