

# INMAN ALIGNER TREATMENT

## INFORMED CONSENT

Our goal is to accomplish a high quality cosmetic orthodontic result in a reasonable time frame for our adult patients. Since orthodontic treatment is extended over a period of time, however, it is essential that a close and cooperative relationship exist between you and our office. To support these objectives, we ask that you:

1. FOLLOW the treatment instructions given to you, particularly in regard to wearing the Inman Aligner Appliances.
2. BRUSH YOUR TEETH thoroughly after each meal and before going to bed. Poor oral hygiene and/ or improper brushing techniques can result in undesirable effects to teeth as well as surrounding tissue (puffy, bleeding gums, and white spots on teeth.) FAILURE TO MAINTAIN GOOD ORAL HYGIENE MAY CAUSE PERMANENT GUM DAMAGE. INFLAMMATION AND BLEEDING GUMS WILL DELAY YOUR TREATMENT.
3. PROFESSIONAL DENTAL CLEANING appointments should be made for every 6 months.
4. KEEP your regularly scheduled periodic orthodontic treatment visits.

Teeth have a tendency to rebound to their original positions after orthodontic treatment. This is called relapse. Very severe problems have a higher tendency to relapse more and the most common type of relapse occurs with twisted teeth. After treatment, retainers will be placed to minimize relapse. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in many cases over correct in order to accommodate the rebound tendencies. Splinting teeth together with cement behind the teeth will help prevent relapse.

In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease later in life the root resorption could reduce the longevity of the affected teeth. It should be noted that not all root resorption arises from orthodontic therapy. Trauma, impaction, endocrine disorders or idiopathic (unknown) reasons can also cause root resorption.

There is also a risk that a problem may occur in the temporomandibular joints (TMJ). Although this is rare it is a possibility. Tooth alignment or bite correction can improve related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains.

I agree that my orthodontic fees will be paid in full when the impressions are taken for the retention phase of treatment.

I understand that additional charges (beyond the quoted orthodontic treatment fee) will be made for splinted retainers, lost appliances, broken appliances, and excessive missed appointments. These events may also lengthen treatment time.

I understand I am responsible for the retention phase of my treatment. We recommend retainer wear, at least part time for a period of years.

I understand that the main objective of my orthodontic treatment is to align my front teeth for cosmetic reasons. My occlusion, or bite, and the relationship of my back teeth will not be changed significantly. Significant changes in lip profile necessitate bone surgery which I am not seeking. I am aware of these objectives and limitations of short term treatment.

I understand that room needed to correct the mal-positioned teeth may be created using a proven and safe technique called Tooth Slenderizing or Interproximal Reduction.

There is no guarantee as to completion within six months, but the majority of cases are treated within that time frame.

On rare occasions, Doctors may visit our office to observe Dr. \_\_\_\_\_ treatment techniques. Pictures may be used for articles, teaching, or advertising. If you have any objection, please inform us.

If you plan on moving to another state during orthodontic treatment it is recommended you complete treatment with our office. Although this may be difficult, methods of orthodontic treatment may vary between doctors, it is infrequent that two doctors will treat a case in exactly the same way. Changing Doctors mid-treatment always prolongs treatment and adds expense to the patient.

ADDITIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read and understand this consent form and I have been given the opportunity to ask questions about my treatment.

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Thank you for the confidence you have placed in us.