DENTAL BEAUTY PARTNERS

Orthodontics Form

1. PATIENT DETAILS

It is important that you understand the orthodontic treatment we will be providing for you. A member of staff will go through this form with you, please ask any questions you have.

Name

Date of Birth

/ /

Orthodontist

PROPOSED COURSE OF TREATMENT

- ☐ Fixed appliances – metal/ceramic
- ☐ Removable appliances
- ☐ Interproximal enamel reduction
- ☐ Expose and bond of impacted teeth
- ☐ Study models
- ☐ Retainers
- ☐ Photographs
- ☐ Extractions
- ☐ Other (please specify below)

2. CLINICAL PHOTOGRAPHY CONSENT

We routinely take photographs of all our patients before, during and after treatment. These form part of the patient's clinical records and are essential for monitoring the progress of treatment.

Some of our patients are happy for us to use their photographs for case presentation or marketing. If we use your photographs, we will never identify you and you remain within your rights to refuse your photographs being used at any time.

I consent to clinical photography which forms part of my clinical records only, this consists of the following:

1. Start of treatment photos
2. Progress photos
3. End of treatment photos

Please tick relevant boxes and sign where indicated:

☐ Yes, I do consent ☐ No, I do not consent

I consent to clinical photography for educational purposes e.g., case presentations and for the purposes of social media and marketing.

☐ Yes, I do consent ☐ No, I do not consent

Signed

3. STATEMENT OF HEALTH PROFESSIONAL

I have explained the intended benefits to the patient, in particular:

- ☐ Improved smile aesthetics
- ☐ Other (please specify below)

4. SERIOUS OR FREQUENTLY OCCURRING RISKS:

- ☐ Discomfort/trauma to oral soft tissues
- ☐ Root resorption
- ☐ Decalcification of enamel
- ☐ Relapse
- ☐ Black triangles
- ☐ Gum disease
- ☐ Gum recession
- ☐ Failure of exposure and bonded tooth to align
- ☐ Loss of nerve supply / blood supply to tooth/teeth, requiring further dental treatment at cost to patient
- ☐ Other (please specify)

Extra procedures that may be necessary:

Limitations of treatment:

5. RESPONSIBILITIES OF PATIENT

- ✓ Maintain good oral hygiene
- ✓ Attend for regular orthodontic appointments
- ✓ Maintaining a low sugar diet
- ✓ Wear your retainers following treatment as specified
- ✓ Wear your appliances as specified
- ✓ Attend for regular check ups at your general dentist

6. FURTHER INFORMATION

I have also discussed what the treatment course is likely to involve, benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of the patient. Your follow up appointments will be the orthodontic therapist under prescription from Dr Jaya. Orthodontic emergencies will be seen within 7 working days.

THE FOLLOWING INFORMATION / LEAFLETS HAVE BEEN PROVIDED:

- ☐ BOS website
- ☐ Fixed appliances
- ☐ Risks of treatment
- ☐ Retainers
- ☐ Other (please specify)

7. SIGNATURES

Orthodontist

Date / /

Signature

STATEMENT OF PATIENT: I agree to the treatment I have been told about

Name

Date / /

Signature