Hume Dental Group
1 Katryn Street, Fawkner Vic 3060
03 93574477
info@hume.dental
ABN: 90 109 826 066

Clear Aligners Consent Form

(Please complete with three patient identifiers: Full Name, Date of Birth, and Contact Number/Address)

Patient Name: _____
Date of Birth: _____
Phone/Address: _____

Treating Dentist: Dr. _____
Date: _____

Treatment Information

You are starting **clear aligner treatment** to straighten your teeth and improve your bite. Treatment involves a series of removable plastic trays worn for the recommended number of hours per day.

Important Information

- Aligners must be worn **20–22 hours per day** for the best results.
- Not wearing aligners as instructed can **extend treatment time** or affect the final outcome.
- Attachments may be placed on teeth to help movement.
- Refinement aligners may be needed to achieve the best result.

Risks and Possible Issues

I understand that:
☐ Mild discomfort or pressure is normal
☐ Speech may be temporarily affected
☐ Cavities, gum inflammation, or staining may occur if oral hygiene is poor
☐ Teeth may not move as planned if aligners are not worn correctly
☐ Retainers will be required after treatment to maintain results
☐ The final result cannot be guaranteed

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Alternatives Discussed

☐ Braces
☐ No orthodontic treatment
☐ Referral to a specialist orthodontist

Patient Responsibilities

- Wear aligners as instructed
- Clean aligners and teeth regularly
- Attend scheduled appointments
- Inform the dentist if aligners are lost or damaged

Consent

I confirm that:

- The treatment, risks, and alternatives have been explained to me.
- I have had the chance to ask questions.
- I consent to begin clear aligner treatment at Hume Dental Group.

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature (if under 18): _____
Dentist Signature: _____ **Date:** _____