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

Orthodontic Treatment 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/Orthodontist: Dr. _____
Date: _____

Procedure Details

You are beginning **orthodontic treatment** to improve the alignment of your teeth and bite. This may involve braces, clear aligners, or other orthodontic appliances.

Important Information

- Orthodontic treatment may take **months to years**, depending on the case.
- Good oral hygiene is essential to prevent **decay, gum disease, and staining** around brackets or attachments.
- Breakages or lost aligners may **extend treatment time**.
- Regular appointments must be attended for best results.
- Some discomfort or pressure is normal after adjustments.

Risks and Possible Complications

I understand that orthodontic treatment may involve:
☐ Tooth sensitivity or discomfort
☐ Root resorption (shortening of tooth roots)
☐ Decay, gum inflammation, or staining if oral hygiene is poor
☐ Relapse (teeth moving back) if retainers are not worn

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☐ Small enamel wear spots or marks
☐ Longer treatment time if appointments are missed or appliances break

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Alternatives Discussed

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

Patient Consent

I confirm that:

- The treatment plan, risks, and alternatives have been explained to me.
- I have had the opportunity to ask questions.
- I understand my responsibilities, including appliance care and oral hygiene.
- I consent to proceed with orthodontic treatment.

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