

I acknowledge that I have read and understand the "You and Your Orthodontist" information booklet outlining general treatment considerations and potential problems and hazards of orthodontic treatment and that actual results may be different from the anticipated results. I also understand that there may be potential hazards and problems not described in the booklet. I am able to read, write and comprehend English. I have had the opportunity to discuss treatment considerations, alternative treatments and risks, and have been asked to make a choice about my orthodontic treatment with

Doctor's Name

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I have asked all questions to clarify any areas I did not understand and I am satisfied with the response(s) received. I further understand that, like the other healing arts, the practice of orthodontics is not an exact science and, therefore, results cannot be guaranteed. I authorize the above orthodontist and staff of his/her practice to provide orthodontic treatment to

Patient's Name

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THE PRESCRIBED TREATMENT WAS EXPLAINED TO ME ON (DATE)

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In accordance with healthcare privacy practices and HIPAA regulations, I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand once released, the above doctor(s) and staff have no responsibility for any shared information by the individual receiving this information.

PATIENT'S SIGNATURE

DATE

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PARENT'S SIGNATURE

DATE *(if required)*

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DOCTOR'S SIGNATURE

DATE

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WITNESS SIGNATURE

DATE

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I also give permission for the use of photographs and records made in the process of examination, treatment and retention to be used for the purposes of research, education, or publication in professional journals.

PATIENT'S SIGNATURE

DATE