Supplemental Informed Consent

for Limited or Compromised Orthodontic Treatment

The goal of orthodontic treatment is to attempt to achieve an ideal esthetic, functional, and stable result. However, there may be times when an ideal result is not feasible and/or there are treatment procedures which are recommended but not desired by the patient. In such cases, a limited treatment plan or a compromised result may be one possible option suggested by your orthodontist. However, before choosing such an option, the patient must be aware of possible long-term consequences of such treatment and accept that fact that the treatment will only address some of the problems that could/should be treated.

- Your bite may not be completely corrected, and your teeth may not be as straight as they could be.
- If your bite is not corrected, your teeth may be more prone to wearing unevenly.
- You may be more prone to problems with your gums and supporting bone around the teeth and to shortening of the roots of the teeth especially when impacted or unerupted teeth are present and left untreated.
- Your teeth may be more prone to return to their original positions.
- In cases where there is a skeletal problem present that would require orthognathic surgery to correct, merely aligning the teeth without the correction of the skeletal problem might make the skeletal problem appear worse and may make it impossible to correct the skeletal problem in the future.
- Patients who chose clear aligners in cases where fixed appliances (braces) are indicated and recommended by the orthodontist, might find treatment times extended and the final result compromised.
- Additional consequences may include: _____

I hereby acknowledge that I have read and understand the above statements, that I understand the risks and possible consequences of limited treatment or a compromised result, that I have discussed this form with the undersigned orthodontist and have been given the opportunity to ask questions and have had any questions answered to my satisfaction.

_____	_____	_____	_____
Signature of patient/parent/guardian	Date	Witness	Date

I have the legal authority to sign this on behalf of _____
Name of patient

_____	_____
Print name	Relationship to patient

_____	_____
Signature of orthodontist	Date