Risks and Limitations of Laser Treatment

Supplemental Informed Consent

Your orthodontist has recommended laser treatment to cosmetically or functionally enhance or expedite your (or your child's) orthodontic treatment result. Generally, the use of a laser to treat the oral tissues is a safe and predictable procedure. As with any procedure, the outcome cannot be guaranteed. The purpose of this document is to help you be aware of possible risks before agreeing to laser treatment.

Occasionally, laser treatment might be used to improve the appearance of individual teeth by altering the gum line or gum margin. If a soft tissue laser is used for this purpose, upon healing, the level of the gum line might not be perfectly symmetrical. If needed, this can often be improved by additional laser treatments or by a periodontist (gum specialist). Occasionally, laser treatment might be used to improve the appearance of individual teeth by altering their shape or size.

Damage to the oral tissues might result from laser treatment. This is generally a self-limiting short-term injury that usually is resolved without additional treatment. In rare circumstances, additional dental and/or medical treatment might be necessary.

A topical anesthetic and/or local anesthetic will be applied to the gums before the procedure. Has the patient had any adverse effects from dental anesthesia? Yes ☐ No ☐

Protective glasses must be worn by all persons near the laser. Failure to do so might result in permanent eye damage.

Laser treatment in areas near large blood vessels (under the tongue, for example) could possibly damage the blood vessels. If damage occurs, additional medical or dental treatment might be necessary.

The chemicals in tobacco can interfere with healing after laser treatment. Does the patient use any form of tobacco? Yes ☐ No ☐

I have read and understand the above. I have discussed this form with my orthodontist and have had the opportunity to ask questions. I consent to laser treatment for:

Patient Name _____

And authorized the orthodontist to perform this treatment.

_____ _____

Signature of orthodontist/group name Date

_____ _____

Signature of patient/parent/guardian Date

_____ _____

Witness Date