**INFORMATION ABOUNT YOUR ORTHODONTIC TREATMENT**

Dental Check-ups

You must continue to see the family dentist regularly throughout your orthodontic treatment for check-ups and scaling of the teeth.

Treatment Times

Most orthodontic treatment will last at least between 18-24 months. This time will vary according to your individual needs. However, there is significant evidence to show that damaged brace or missed appointments will increase your treatment time. You must be prepared to attend for appointments on a regular basis. We will try our best to accommodate you out of school or working hours.

Discomfort

It is common to experience tenderness when the brace is filled or adjusted and this will usually take 2-3 days to reduce but can take 1-2 weeks to completely disappear.

Dietary Habits

Hard, sticky and chewy foods damage and break your braces and bend the wires. This stops tooth movement and increases the length of treatment. Food and drinks high in sugar content and acid will cause tooth decay and permanent unsightly white and brown marks on the teeth which may only be noticeable to you when the braces are removed.

Oral Hygiene

Poor tooth brushing around the braces leads to tooth decay, gum disease and unsightly white / drown marks on the teeth (decalcification). You must be prepared to spend longer time on the brushing your teeth whilst wearing the braces otherwise irreversible damage may occur. Fluoride mouthwash and toothpaste can help prevent these marks but by no means should this be used as a substitute for good tooth brushing. It is recommended that your clean your teeth at least three times a day concentrating on the gums and ensuring that you clean underneath your wire as shown by your orthodontist.

Root Shortening

Slight shortening of the root ends usually occurs during orthodontic treatment but will not cause any long-term problems in healthy mouths. However, severe root shortening can occasionally occur but this is rare.

Teeth that have had previous damage / trauma

Very rarely, orthodontic treatment can aggravate the nerves in the previously knocked / damaged teeth which may require attention by your dentist.

Elastic Bands

Your Orthodontist may ask you to wear elastics to help tooth movement as part of your treatment. Failure to wear these as instructed will prolong your treatment and may lead to your teeth moving incorrectly.

Retainers

Following completion of treatment all patients will be provided with retainers to maintain the improvement and alignment and your new smile, and his will be monitored by your orthodontist for one year. It is your responsibility to wear your retainers as instructed. If the retainers are not worn the teeth may move back towards their start position. Indefinite wear of retainers is currently deemed necessary to maintain complete alignment and prevent relapse. Further monitoring after the first year and replacement retainers will incur a charge.

Discontinuation of treatment

Good co-operation is fundamental to achieving a good result in as short a time as possible. Broken braces, missed appointments, failure to maintain good oral hygiene and wear your elastics may mean that your braces have to be removed early possibly leaving gaps, teeth sticking out or teeth that are not as straight as they should be to prevent damage to your teeth.

If your brace is broken or causing problems, then you should contact on **0302227196** as soon as possible to arrange an extra appointment. Please do not attend the facility without making an appointment first.

## ORTHODONTIST’S CONSENENT FORM

## **NAME: DATE OF BIRTH:**

## 

## **ADDRESS:**

## **Benefit of Treatment**

## Align Teeth

## Correct Bite

## Improve Appearance

## **Estimated Duration of Treatment**

## **Description of Treatment**

## 

## UPPER REMOVABLE APPLIANCE

## GROWTH BRACE

## REMOVAL OF ADULT TEETH

## UPPER AND LOWER GLUED ON BDRACE

## HEAD BRACE

## TEMPORARY ANCHORAGE DEVICE/IMPLANT

## RETAINERS (↑Bonded ; ↓Bonded)

## Patient made aware of long term maintenance and cost associated with bonded retainers ☐

## MODIFICATION OF TOOTH SHAPE / TOOTH SIZE

## PHOTOS (for medical records)

## FRENECTOMY (Removal of tag of skin between the two front teeth)

## ADJUNTIVE TREATMENT Replacement to missing teeth

## Jaw surgery

## **Other**

## ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

## I confirm that I have explained the proposed treatment to the patient along with the risks and possible treatment options

## Signature…………………………………DR……………...............…………….……………….Date…………………

## I agree to the proposed orthodontic treatment that has been explained to me and I have read the accompanying information on this consent form and understand the risks, benefits and alternative treatment options associated with my orthodontic treatment.

## **Signature of Patient or Parent/Guardian**

## Signature…………………………………....................................................Date.………………………….

## Name (Print)……………………………………...................Relationship to Patient ………………………

**Copy of consent form accepted by Patient / Guardian: Yes / No (Please circle)**