ORTHODONTIC TREATMENT CONSENT & AGREEMENT PACKAGE (METAL / CERAMIC BRACES)

1. Patient Information & Medical History Form

Personal Information

Full Name:

_____

Date of Birth: _____

NIC/Passport Number: _____

Phone Number: _____ Email Address:

_____

Address:

_____

Medical History & Suitability Assessment

Question	Yes	No	If Yes, Provide Details
Do you have any jaw joint issues or TMJ discomfort?	☐	☐	
Are you taking any long-term medications (e.g., steroids, bisphosphonates)?	☐	☐	
Do you have a history of gum disease or bone loss?	☐	☐	
Are you allergic to metal, latex, or dental materials?	☐	☐	
Are you pregnant or planning to become pregnant during treatment?	☐	☐	
Have you had any previous orthodontic treatment?	☐	☐	

I confirm the above information is accurate. I understand that non-disclosure may affect treatment outcome.

Patient Signature: _____

Date: _____

Doctor's Name & Signature: _____

2. Orthodontic Treatment Consent Form

I, _____ (Patient Name), consent to undergo fixed orthodontic treatment (metal or ceramic braces) at Veritas Dental Lounge. I understand and accept the following:

- Braces are used to correct alignment issues and may take 18–36 months or longer depending on complexity.
- Regular adjustments (every 4–8 weeks) are necessary.
- Braces may cause discomfort, ulcers, or speech changes during adaptation.
- Oral hygiene is essential to avoid white spots, cavities, or gum inflammation.
- Food restrictions apply—hard, sticky, and sugary items must be avoided.
- Brackets may dislodge or break, requiring repairs at an additional cost if due to misuse.
- Ceramic braces are more aesthetic but fragile and may stain.
- Treatment may require extractions or use of elastics and auxiliaries.
- Results depend on compliance with instructions, hygiene, and regular visits.

I have been informed of alternative treatments (e.g., clear aligners) and voluntarily choose fixed braces.

Patient Signature: _____
Date: _____
Doctor's Signature: _____

3. Pre-Treatment Instructions & Guidelines

- Brush and floss before appointments.
- Avoid eating 2 hours before bonding appointment.
- Inform the doctor of any medication or recent dental work.

4. Post-Treatment Care & Responsibilities

- Brush after every meal and use interdental brushes.
- Avoid biting hard items like pens, ice, or nuts.
- Follow all dietary restrictions strictly.
- Attend all scheduled adjustment appointments.
- Notify the clinic immediately if brackets/wires break or cause pain.
- Retainers are mandatory after braces removal to prevent relapse.

5. Financial Agreement & Refund Policy

- A non-refundable deposit is required to initiate treatment.
- Full payment or agreed installments must be completed before debonding and retainer issue.
- Missed appointments or non-compliance may delay treatment and incur additional costs.
- Refunds are not applicable once appliances are fabricated or treatment has commenced.

6. Liability Waiver & Dispute Resolution Clause

- I acknowledge that the success of orthodontic treatment depends on my cooperation.
- Veritas Dental Lounge is not liable for complications due to poor oral hygiene, missed visits, or non-compliance.
- Disputes will first be resolved through mediation, and if unresolved, under Sri Lankan law.

7. Photography & Marketing Consent (Optional)

☐ I consent to the use of my orthodontic treatment photos for educational/marketing use (no identifying details).

☐ I do NOT consent to the use of my photos.

Patient Signature: _____
Date: _____

8. Maintenance Charges & Additional Costs

The following maintenance-related services may be required during your orthodontic treatment. These items are not covered under the original treatment package and will be charged separately if needed:

Item / Service	Charge (LKR)
Replacement of Broken Bracket (per unit)	
Loose Molar Band or Tube Reattachment	
Archwire Replacement (due to damage/misuse)	
Emergency Visit (outside regular appointments)	
Repositioning of Bracket (non-clinical reasons)	
Ligature / Elastic Chain Replacement (excessive)	
Lost or Broken Retainer (per arch)	

Note: Charges may vary based on materials used. Patients will be informed in advance.

Patient Acknowledgment:
I acknowledge that the above charges may apply if additional or corrective services are required during or after my treatment.

Patient Signature: _____ **Date:** _____
Doctor's Signature: _____

9. Treatment Plan Details

This section summarizes the individualized orthodontic treatment plan as discussed between the patient and treating orthodontist.

Treatment Component	Details
Type of Braces	☐ Metal ☐ Ceramic
Number of Arches Treated	☐ Upper ☐ Lower ☐ Both
Estimated Treatment Duration	_____ months
Adjustment Frequency	Every _____ weeks
Extractions Required	☐ Yes ☐ No If yes, specify: _____
Use of Elastics / Auxiliaries	☐ Yes ☐ No
Additional Appliances (if any)	_____
Estimated Date of Debonding	_____
Retainer Type Planned	☐ Essix ☐ Hawley ☐ Fixed

Treatment Goals:

Patient Acknowledgment:
I confirm that the treatment plan above has been explained to me and I understand the steps, expectations, and commitment required.
Patient Signature: _____ **Date:** _____
Doctor's Signature: _____