

## CLEAR ALIGNER TREATMENT CONSENT & AGREEMENT PACKAGE

### 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 history of gum disease or periodontal issues?                         | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Do you experience jaw pain, clicking, or TMJ issues?                                  | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Have you been diagnosed with osteoporosis or bone loss issues?                        | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Are you currently taking any medications (including bisphosphonates)?                 | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Do you have diabetes, heart conditions, or other chronic illnesses?                   | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Are you pregnant or planning pregnancy during treatment?                              | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Have you had orthodontic treatment before (braces, retainers, aligners, etc.)?        | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Do you have any known allergies (especially to plastics, latex, or dental materials)? | <input type="checkbox"/> | <input type="checkbox"/> |                         |

I certify that the above information is accurate to the best of my knowledge. I understand that failing to disclose medical conditions may impact my treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Name & Signature: \_\_\_\_\_

### 2. Clear Aligner Treatment Consent Form

I,

\_\_\_\_\_  
\_\_\_\_\_

(Patient Name), understand that clear aligners are a removable orthodontic appliance designed to gradually move my teeth. I acknowledge the following:

- Aligners must be worn for at least 22 hours per day.
- Missing aligner wear time may prolong treatment and affect results.
- Temporary discomfort or tightness when switching to new aligners.

- Speech changes in the initial stages of treatment.
- Risk of cavities or gum disease if oral hygiene is not maintained.
- Teeth may relapse if retainers are not worn post-treatment.
- IPR (Interproximal Reduction) may be required.
- Attachments may be bonded to teeth to aid movement.
- Refinement aligners may be needed if progress is not as expected.
- The predicted timeframe is \_\_\_\_\_ days, but individual results may vary.
- A retainer is mandatory after aligner treatment to prevent shifting.
- Progress Monitoring Requirement:
- The patient must upload photos of their progress every 10 days using the designated online form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

### 3. Pre-Treatment Instructions & Guidelines

- Cavities, infections, or gum issues must be treated before starting aligners.
- Aligners must be worn for 22 hours daily.
- Change aligners every \_\_\_\_\_ days as instructed.
- Remove aligners before eating or drinking anything except water.
- Rinse your mouth before reinserting aligners.
- Brush and floss after meals to prevent plaque buildup.
- Clean aligners with lukewarm water and a soft toothbrush (no toothpaste).
- Do not use hot water, as it can warp the aligners.

### 4. Post-Treatment Care & Responsibilities

- A retainer is required to prevent teeth from shifting back.
- Retainers must be worn full-time for the first 6 months, then at night indefinitely.
- Continue regular dental checkups every 6 months.
- Maintain good oral hygiene to prevent relapse and decay.

### 5. Financial Agreement & Refund Policy

- All payments must be completed before the final aligner set is issued.
- Aligners will not be replaced for free if lost or damaged.
- The initial deposit is non-refundable once aligners have been manufactured.
- If the patient chooses to discontinue treatment, no refunds will be issued for aligners already received.

### 6. Liability Waiver & Dispute Resolution Clause

- Aligner treatment outcomes depend on biological factors beyond the clinic's control.
- Treatment success is not guaranteed.
- Veritas Dental Lounge is not responsible for mild discomfort, speech issues, or non-compliance affecting treatment results.
- Disputes shall first be attempted to be resolved via mediation.
- If mediation fails, legal proceedings shall be conducted under the jurisdiction of Sri Lanka.

### 7. Photography & Marketing Consent (Optional)

☐ I consent to Cayo Dental using my before-and-after photos for educational or marketing purposes. No identifying details will be shared.

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 8. Maintenance Charges & Additional Costs

During the course of clear aligner treatment, certain maintenance services or replacement items may incur additional charges. These costs are not included in the initial treatment fee and will be payable separately if applicable.

| Item / Service                                         | Charge (LKR) |
|--------------------------------------------------------|--------------|
| Replacement of Lost or Damaged Aligner Tray (per arch) |              |
| Additional Refinement Aligners (if required)           |              |
| Replacement of Retainers (Essix – per arch)            |              |
| Emergency Consultation (outside scheduled visits)      |              |
| Aligner Tray Adjustment or Trimming                    |              |
| Re-scanning for Mid-Course Corrections (if needed)     |              |
| Transfer Letter or Digital Case Summary                |              |
| Retainer Storage Box / Travel Case                     |              |

*Note: These charges are subject to revision and may vary based on clinical needs or material cost changes. Patients will be informed prior to billing.*

## Patient Acknowledgment: