INVISALIGN™ ORTHODONTIC TREATMENT INFORMED CONSENT

_____ _____

Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make an informed decision about your treatment. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. In order to increase the chance of achieving optimal results, you have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable). Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: _____

Procedure: _____

Alternative options: _____

1. I have been informed of and understand the potential risks related to this procedure include but are not limited to:
    - Varying lengths and degrees of discomfort, gum irritation, enamel decalcification, increased risk of tooth decay, tight feeling after adjustments, bone loss, loose tooth/teeth, cuts inside the mouth or on the lips, stress or damage to the jaw joints (TMJ), altered bite, altered speech, possible breakage/dislodgement/bond failure of material, change in aesthetic appearance of teeth, gum recession, root resorption with subsequent loss of teeth, difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials.

2. I have been informed of and understand that follow up visits or care, additional evaluation, and/or treatment or surgery may be needed.

3. I have been informed that orthodontic treatment does not ensure a lifetime of perfectly straight teeth. Retention options will be discussed with me after the procedure.

4. Patient's Responsibilities

    I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

    I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any problems as they arise. My failure to comply could result in complications or less than optimal results.

    I understand and accept that the doctor cannot guarantee the results or time frame of the treatment. I had sufficient time to read this document, understand the above statements, and have

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had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_____ _____

Doctor Signature Date