CONSENT FOR 6-MONTH/FAST ORTHODONTIC TREATMENT

I, _____, have chosen the treatment option of 6-month/fast braces to resolve the crowding of my upper front teeth by Dr. Victor Sun. I have been given the option of traditional comprehensive Orthodontic treatment but I chose to go with 6-month/fast braces treatment modality to improve the alignment of my upper front teeth. I understand Dr. Sun is a general dentist who has received additional training in providing Orthodontic treatment to his patients and he is not an Orthodontist but I elect Dr. Victor Sun to provide the treatment on me.

I have been explained by Dr. Sun and I understand that the objective of 6-month/fast braces is to only straighten my upper front teeth in order to improve my smile. I understand that with 6-month/fast braces, my overall occlusion(bite), particularly in the back of my mouth, will not be altered. It will not improve the overall occlusion of my mouth.

I have also been explained that the following potential complications, although remote, may occur with 6-month/fast braces: sore teeth during or after treatment which may require root canal treatment, temporo-mandibular disorder, oral-facial pain, temporo-mandibular joint dysfunction, roots shortening, decalcification of the enamel of the teeth, increased overjet between the upper and the lower front teeth, other unusual occurrences etc.

I understand that during treatment, I need to carry good oral hygiene in order to minimize the chance of getting decay in my teeth. I also understand that I need to wear my retainers diligently after treatment in order to prevent post-treatment tooth movement(Relapse) .

I have read and fully understand the above consent and I do not have any further question about my treatment.

_____ _____

Print Name: Date

_____ _____

Parent/Guardian: Date