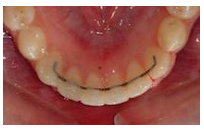
The Hub Dental Practice

Consent form for Orthodontic Retainer/Splint

Vacuum-formed retainer. This is a clear retainer that is usually worn on a part-time basis. You must never eat or drink with the retainer in place. Initially it grips your teeth firmly, but most patients adapt very well to this type of retainer.



Bonded retainer. This is a fixed type of retainer. This is stuck onto the teeth – usually hidden on the inside of the teeth, so it is not visible. The advantage is that you don't need to remember to wear this retainer (as it stuck in full-time). However, you must spend extra time cleaning around it and if it ever gets loose, you should seek advice.

I acknowledge that I am having a Retainer/Splint made at the practice.

I certify that I have been advised to see a Dentist prior to having a retainer/splint made.

I acknowledge that I am have been told that I need to make an appointment to see an ORTHODONTIST within 1 month to review the retainer and the state of my dentition/occlusion.

The dentist that examined me has fully explained to me the purpose of the procedure(s) and has also informed me of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the purposed treatment, including no treatment.

The attendant risks of no treatment have also been discussed.

I certify that the dentist who examined me that the success of all treatment is determined in a big way by following post treatment instructions, and that these are always given to patients after treatment, both verbally and in writing, and it is essential that patients read and keep them. Please make sure you have them and do not be afraid to ask for them!!!

I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

I have been give the opportunity to delay my decision/treatment and/or seek a second opinion

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) which the above named dentist or his/her associates may consider necessary.

I acknowledge that no guarantees or assurances have been made to me about how long the retainer/splint will last and that if it breaks or is damaged or otherwise does not fit there will be a charge made for a replacement.

I acknowledge that I have been told that I may have to wear a retainer indefinitely and that it will require replacement on a regular basis, depending on usage etc and there will be a charge made for each replacement.

I acknowledge that I have been told how to look after and clean the retainer and been told the importance of Good Oral Hygiene, Sugar intake, Fluoridated toothpaste and regular Hygienist and Dentist appointments,

I acknowledge that I have been told the importance of wearing the retainer and the likely consequences of failing to wear the retainer.

I also understand the financial obligation attached to this procedure carried out today and agree to comply as listed below.

Type of Retainer (s) _____ Total amount due £……

I understand that I am responsible for all fees. I also understand that as treatment progresses the above fees may have to be adjusted, but that I will be informed of these adjustments and how will affect my payment plan.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

Warranty: Retainers are not permanent and depending on usage will have a variable lifespan. **Therefore we will only offer a 6 Month Warranty when we will replace any damaged plastic retainer or re-cement any metal retainer without charge.**

After 6 months additional charges will apply for all repairs and all replacements.

I realize that signing does not mean that I am under an obligation to have any treatment and that I may decide not to proceed with all or any part of the treatment. Similarly signing this means that I only pay for the treatment that I have actually had done.

I hereby consent to the proposed dental treatment acknowledge that it is being provided as a **Private Patient**.

Name _____ Date of Birth ____//____//_____

Signature _____ Date ____//____//_____