LUMILIGNER CONSENT FORM

I acknowledge that my dentist has discussed the following information with me:

1. Treatment Process

   a. I understand that LUMILIGNER treatment involves a series of custom-made aligners that are worn over the teeth. These aligners are designed to gradually shift teeth into a more desired position.
   b. I understand that I will be required to wear the aligners for a specified amount of time each day, typically 20 to 22 hours, and will change to a new set of aligners approximately every 1-2 weeks depending on my dentist's specific instructions.
   c. I acknowledge that the success of my treatment depends on my commitment to wearing the aligners as directed by my dentist.
   d. I understand that small tooth-coloured attachments may be necessary to facilitate tooth movement. These attachments will be placed on certain teeth and are a crucial part of the treatment process.
   e. I understand that Interproximal Reduction, or the removal of a small amount of enamel between teeth, may be necessary to create space for proper alignment. This procedure is done with care and precision to ensure optimal treatment results.

2. Duration of Treatment

   a. I understand that the duration of my LUMILIGNER treatment may vary depending on the complexity of my case and my compliance with wearing the aligners.
   b. I acknowledge that my dentist has shown me my LUMIPLAN (a digital simulation showing what my teeth may look like once straightened) and provided me with an estimated treatment timeline, but the actual duration may differ.

3. Risks and Benefits

   a. I understand that while LUMILIGNER treatment is generally considered safe and effective, there are risks associated as with any dental procedure.
   b. I acknowledge that potential risks of LUMILIGNER treatment may include but are not limited to:
      i. Discomfort or soreness during the initial adjustment period of wearing new aligners.
      ii. Irritation or mild discomfort due to the edges of the aligners.
      iii. Allergic reactions to the materials used in the aligners (although rare).
      iv. Changes in speech patterns, particularly, during the initial adjustment period.
      v. Incomplete correction of dental issues, requiring additional treatment.
   c. I understand that the benefits of LUMILIGNER treatment may include:
      i. Improved dental aesthetics and smile appearance.
      ii. Correction of bite issues, such as overbite, underbite or crossbite.
      iii. Enhanced oral hygiene compared to traditional braces, as the aligners are removable to accommodate eating, drinking and cleaning.

4. Maintenance and Care

a. I understand the importance of maintaining good oral hygiene during LUMILIGNER treatment, including regular brushing and flossing, as well as cleaning the aligners as instructed by my dentist.
b. I acknowledge that failure to properly care for my aligners may result in discolouration and bad odours.
c. I agree to follow all instructions provided by my dentist regarding the care and maintenance of my aligners.

5. Follow-Up Appointments

a. I understand that I will be required to attend regular follow-up appointments with my dentist to monitor the progress of my LUMILIGNER treatment.
b. I acknowledge that adjustments to my treatment plan may be necessary based on my dentist's assessment of my progress.

6. Financial Responsibility

a. I understand that the cost of LUMILIGNER treatment will be discussed with me prior to beginning treatment, including any additional fees for follow-up appointments, replacement aligners, or other services.
b. I acknowledge that payment for LUMILIGNER treatment is my responsibility and agree to fulfil all financial obligations associated with my treatment plan.

7. Alternative Treatment Options

a. I understand that there may be alternative treatment options available for correcting my dental issues, such as traditional braces or other orthodontic appliances.
b. I acknowledge that my dentist has discussed these alternative options with me, but I have chosen LUMILIGNER treatment based on my personal preferences and needs.

8. Consent for Treatment

a. I understand the information provided to me about LUMILIGNER treatment including the risks, benefits and alternatives.
b. I acknowledge that I have had the opportunity to ask questions and have received satisfactory answers from my dentist.
c. I hereby give my informed consent to undergo LUMILIGNER treatment as outlined by my dentist.

Patient Name: ____ Date of Birth: ______________________________

Patient Signature: ____ Date: ____

Dentist Name & Address: ____

Dentist Signature: ____ Date: ____

Please keep a copy of this consent form for your records.

If you have any questions or concerns before, during, or after your LUMILIGNER treatment, do not hesitate to contact us.