Risks and Limitations of Laser Treatment

Dr. Ising has recommended laser treatment to cosmetically or functionally enhance or expedite your (or your child's) orthodontic treatment result. Generally, the use of a laser to treat the oral tissues is a safe and predictable procedure. As with any procedure, the outcome cannot be guaranteed. The purpose of this document is to help you be aware of possible risks before agreeing to laser treatment.

Occasionally laser treatment might be used to improve the appearance of individual teeth by altering the gum line or gum margin. When a soft tissue laser is used for this purpose, upon healing, the level of the gum line might not be perfectly symmetrical. If needed, this can often be improved by additional laser treatments or by a periodontist (gum specialist). Occasionally laser treatment might be used to improve the appearance of individual teeth by altering their shape or size.

Laser treatment is also used to uncover impacted (Stuck) teeth. Occasionally, the tooth is impacted too deeply and may require referral to an Oral Surgeon for uncovering.

Damage to the oral tissues might result from laser treatment. This is generally a self-limiting short-term injury that usually resolves without additional treatment. In rare circumstances, additional dental and/or medical treatment might be necessary.

Protective glasses must be worn by all persons near the laser. Failure to do so might result in permanent eye damage.

Laser appointments are also very important to Dr. Ising as they are in very high demand. 48 hours advanced notice is required to reschedule or a $100 rescheduling fee will apply. No show/no calls will not be rescheduled.

A topical anesthetic and/or local anesthetic will be applied to the gums before the procedure. Has the patient ever had an adverse reaction to anesthetics? **Please circle: Yes No**

Are there any changes in your medical history? **Please circle: Yes No**

If yes, please explain: _____

I have read and understand the above. I have had the opportunity to ask questions. I consent to laser treatment for:

Patient Name _____

And authorize the orthodontist(s) listed below to provide this treatment.

_____ _____

Signature of orthodontist/group name Date

_____ _____

Signature of patient/parent/guardian Date