

# Consent for premature removal of orthodontic appliances

Brian Reising, DDS, MS  
Orthodontic Specialist

traditional and ceramic / clear braces  
implant assisted orthodontics  
hidden / lingual braces  
surgical orthodontics  
invisalign



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Children and Adults

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Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

- I hereby give permission for the premature removal of orthodontic appliances.
- Dr. Reising has informed me that orthodontic treatment has not been completed and has explained the consequences of premature removal of orthodontic appliances:
- I understand that Dr. Reising has recommended continuing orthodontic treatment until ideal results have been achieved and I will not hold Dr. Reising responsible for any consequences which result from the premature removal of orthodontic appliances:

\_\_\_\_\_  
Signature of Patient / Parent / Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Brian C. Reising, DDS, MS

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_