PATIENT COOPERATION AGREEMENT

In order to obtain the best possible results in my orthodontic treatment, I understand that my cooperative efforts are just as important as the efforts of Dr. Klomparens and his staff. The doctor provides the treatment plan, but I am responsible for following his instructions so that I may have beautiful, healthy teeth that last a lifetime.

I will have done my part when I have taken responsibility for the following:

1. **CLEAN TEETH AND GUMS:** I will continue to see my general dentist for cleanings and I will clean my teeth and gums properly at least two (2) times per day, especially after eating meals or snacks. I understand the policy and potential fees for neglecting my oral hygiene.

2. **WEARING APPLIANCES:** I will wear my elastics, headgear, or other removable appliances faithfully as directed by the doctor and staff. I will maintain my “GREAT” smile and wear my retainers as instructed.

3. **CARE OF APPLIANCES:** I will avoid foods and activities that will damage my appliances and delay my treatment. I will always wear a mouthguard for protection when playing sports. I understand the policy and potential fees for excessive broken appliances.

4. **APPOINTMENTS:** I will do my best to keep all of my appointments and arrive on time. I will call as soon as possible (24 hours in advance) if I must change an appointment and always call ahead of time if I have something broken or loose. I WILL COMMIT TO ALTERNATING APPOINTMENT TIMES DURING, BEFORE AND AFTER SCHOOL. I understand the policy and potential fees for having broken appliances and missing appointments.

5. **RETAINER WEAR AND COMPLIANCE:** After completing orthodontic treatment retainers are worn to maintain straight teeth and to stabilize bite correction. Retainers must be worn as instructed by Dr. Klomparens and our Staff and can be a lifelong commitment to protect the valuable investment that has been made by you and your family. Failure to comply with retainer wear can result in the need for re-treatment and the assessment of more orthodontic treatment fees.

As an orthodontic patient receiving treatment in the office of Dr. Robert Klomparens, I agree to cooperate by following all of the above instructions.

Patient Signature ______________________________ Date ______________

Parent Signature ______________________________ Date ______________