The template provided below does not, and is not intended to, constitute legal advice. Instead, all information, content, and materials are for general informational purposes only. You should contact your attorney to obtain advice with respect to any particular issue or question.

Dentsply Sirona Orthodontics Inc. d/b/a SureSmile®

SureSmile® Treatment Consent Form

Congratulations on your decision to pursue orthodontic treatment for you or your child. SureSmile® clear aligners are an excellent choice made by your doctor to create beautiful, new smiles. Please read the following information and make sure that you ask any questions or raise any concerns you may have before signing the Consent Form.

RISKS OF TREATMENT

1) Failing to follow doctor instructions may interfere with achieving treatment objectives. This includes not wearing appliances as directed or missed appointments. All treatment times are estimated and may be extended by eruption of teeth or issues related to patient's specific dentition, including uncommon tooth shape and any other anomaly encountered during treatment.
2) Inadequate patient oral hygiene during treatment may result in decay, gum irritation, tissue disease or permanent discoloration of teeth. In the event that all hygiene instructions are not followed, including regular brushing/flossing and regular practice of standard oral hygiene, intraoral inflammation or gum disease may result.
3) Minor discomfort when switching aligners during treatment is expected. However, any concern regarding pain or difficulty with placing a new appliance should be immediately reported to your doctor or staff. Patient may experience irritation to gums, cheeks or lips during treatment, which should also be communicated to doctor or staff. Allergic reactions are also possible and should be reported as well.
4) Interproximal (space between the teeth) re-contouring or minor shaping may be required to allow space for teeth to move for proper alignment.
5) Orthodontic treatment involves moving teeth and teeth may shift after treatment. Retainers must be worn at the direction of your doctor to control this tendency. In short, wearing retainers post-treatment is essential to maintaining your new smile.
6) In some cases, additional treatment appliances may be required for treatment plans. Such supplemental clinical requirements will be explained by your doctor. These may include the need for oral surgery to correct jaw position or severe crowding, which must be completed prior to aligner treatment.
7) Notify your doctor of any medical conditions/medications as they could affect treatment.
8) Dental implants cannot be moved by aligners. Additionally, existing restorations may require repositioning or replacement as the result of treatment, which may require additional dental, surgical or endodontic treatment. In extreme cases, teeth may be lost.
9) Orthodontic appliances can possibly be swallowed or aspirated. Any looseness of aligners or any other appliance used during treatment should be immediately reported to your doctor. In cases involving extreme crowding or missing teeth, product breakage is more common.
10) As is the case with any public health-care setting, it is possible that the doctor will not always be successful in preventing the transmission of a highly infectious virus. I

assume the risk that I or my minor trustee may be exposed to a communicable disease in the doctor's office and/or by use of SureSmile Aligner products.

SureSmile® Aligner Treatment Consent

Orthodontics is not an exact science, and I acknowledge that Dentsply Sirona Orthodontics Inc. d/b/a SureSmile and its subsidiaries (collectively, "SureSmile") and my doctor have not and cannot make any guarantee or provide any other assurances regarding the outcome of any treatment. I understand that SureSmile is not a provider of medical, dental or health care services and does not and cannot practice medicine, dentistry or give any medical advice. All clinical and treatment decisions made rest with my doctor.

In signing this Consent Form, I am indicating that I understand the risks or options available for orthodontic treatment. Any concerns or questions that I may have had were sufficiently explained or answered by my doctor and I consent to treatment for myself or a minor under my legal care. I also agree that the doctor may provide medical records, including but not limited to, x-rays, reports, charts, medical history, photographs, findings, dental plaster models or impressions, diagnosis, prescriptions, testing and results, billing or any other records regarding treatment and in my doctor's possession relating to me or a minor trustee under my care (collectively "Records") to SureSmile or other licensed dentists or orthodontists. I also agree that SureSmile, including but not limited to its employees or other representatives, successors, or assigns, may release such Records to health care providers or to SureSmile's employees or other representatives, successors, and assigns for any educational, commercial, or research purposes.

I also understand the any use of my medical records may result in the disclosure of my or my minor trustee's "individually identifiable health information" as defined by the Health Portability and Accountability Act ("HIPAA"). I will not, nor anyone acting on my behalf or on behalf of my minor trustee, seek legal, equitable or monetary damages or remedies for such disclosure. I understand that no compensation will be provided for use of my Records, which is without compensation. I acknowledge that I as well as anyone on my behalf shall not have any right of approval, claim of compensation or right to seek legal, equitable or monetary damages or remedies resulting from any use or disclosure permitted under the terms of this Consent Form.

I agree that I have read, understand and agree to terms stated in this Consent Form as indicated my signature below; a photostatic copy of this Consent Form will be regarded as effective and valid as an original.

Print Patient Name:_____

Patient Signature:_____ Date: _____

Guardian Signature
for Minor Trustee:_____ Date: _____

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