**Retention Consent Form**By signing this form, I understand that wearing retainers is the final phase of the orthodontic treatment and that they are required for my teeth to stay in the positions we have worked so hard to put them in. Wearing retainers as instructed, replacing lost of broken retainers, and/or the cost of re-straightening your teeth, if necessary, is my responsibility.

I understand that my teeth have the capability of moving any time throughout life, that it is unpredictable how strong nature’s “push” will be to move my teeth back to their original positions, and it is up to me to fight those tendencies as long as I would like my teeth to remain straight. I understand that is ideal if I would wear a retainer part time (evenings) indefinitely and if I choose at any time to stop wearing my retainer, I am aware that my teeth will move towards their original positions.

By signing below I acknowledge that I understand my responsibilities in wearing the retainers. I also acknowledge that there is an additional cost to replace lost or broken retainers and any necessary re-straightening of teeth. I acknowledge that I am satisfied with the orthodontic results obtained and give my permission to Dr. Diana Fong to remove my child’s braces.

**Patient Name (Please Print) :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/guardian signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(If patient is under 18)*

**Dentist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Initial \_\_\_\_\_\_\_\_ \_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS FORM MUST BE SIGNED AND DATED AND RETURNED
PRIOR TO APPLIANCES BEING REMOVED**

**Dr. Diana C. Fong, D.D.S. 345 9th Street, Suite 304 Oakland, CA 94607 (510)272-0967**

 **Email:** **leefongdds@yahoo.com** **Orthodontics Dentofacial Orthopedics Orthotropics®**