Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

INFORMED CONSENT FOR SPACE MAINTAINER/"SPACER"

What is a space maintainer and what are its benefits?
If a baby tooth is lost prematurely, neighboring teeth may shift and create problems for adult teeth trying to come in later. To minimize this problem a space maintainer is used to hold teeth in their correct positions. This is done by placing bands and wire between teeth to hold them apart from one another.
What are the risks?
1. Since it is a device that is affixed to teeth, diligent care must be used to keep it clean. If not, decay may form from food and plaque buildup that may lead to additional dental treatment.
2. Soreness and sensitivity of the area is to be expected shortly after it is placed
3. The space maintainer may interfere with soft tissue such as the tongue, cheek and gums.
4. The maintainer may come loose and require reseating assuming it will fit again. If not, a new one may need to be made and any additional fees would be discussed at this time.

What are my alternatives?
Not placing a space maintainer is an alternative option, but drifting of teeth may lead to crowding problems later.
By signing the below consent, I understand that it is my responsibility to notify this office should any unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the space-maintainer placed.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of space-maintainer and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Pediatric Dentistry and Orthodontics and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications if needed.

_____ _____

Parent/Guardian's Signature Name of patient receiving treatment

_____ _____

Today's Date Witness's Signature