

PATIENT COOPERATION AGREEMENT

I understand that the success of my treatment is dependent on my cooperation in the following areas:

1. Thorough and frequent brushing and flossing.
2. Avoiding hard and sticky foods.
3. Wearing of elastics, headgear and retainers as recommended for me.
4. Commitment to regular check-ups and cleanings at Nordstrom Dental.

If Dr. Nordstrom feels that oral hygiene is inadequate and the teeth are at serious risk of cavities and/or gum disease he reserves the right to discontinue orthodontic treatment and remove all orthodontic appliances.

Dr. Nordstrom also reserves the right to discontinue treatment for reasons such as, but not limited to, poor attendance for regular orthodontic recalls, poor compliance with headgear, elastics, or retainers, or non-payment/overdue account.

Signature of patient/parent: _____

Date: _____