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Dear Patient/Parent/Guardian:

We respect your right to do what you believe, is in the best interests of your/your child. We are attempting to provide the best possible treatment and outcome for you/your child within the scope of your practice. We always ask what we would do if it were us/our own child when we make decisions. There are cases where we disagree with the patients/parents from a dental perspective and must protect ourselves from potential liability with this release. Please know that your request is given the utmost respect., but our legal counsel requires us to have this form signed in order to remove your/your child's braces. Thank you for placing your trust in us and allowing us to care for you/your child.

I, _____ am the patient/parent and /or legal guardian of the minor _____. It is my desire to have the orthodontic appliances currently in place in my (child's) mouth removed. I understand that I am requesting the removal of the braces against the advice of Dr. Nader Ehsani. I have been advised by Dr. Ehsani that to remove the braces now would be premature and that a better treatment result would be made with waiting until later date when teeth are in better position and have been stabilized. The risk of relapse is extremely high in patients who have their braces/appliances removed prematurely. Tge prematurely removal of the appliances could result, but not limited to, in hazards such as:

- ___ Food Impaction if spaces are not closed
- ___ Cheek Biting
- ___ Tooth wear
- ___ Compromised esthetics
- ___ Overbite not corrected
- ___ Overjet not corrected
- ___ Possible Temporomadibular joint disease

I HEREBY AGREE to release Dr. Ehsani, and any other representative and/or agent working in this office from any and all potential claims, complaints, and/or cause of action as a result of my demand for early removal of the orthodontic appliances. I further agree to indemnify and hold them, and each of them, harmless from any actions which may arise as a result of the premature removal of braces.

I have been fully informed of the consequences of early removal including , but not limited to, potential regression of the teeth and their alignment which could result in not just aesthetic concerns, but functional as well. In spite of this knowledge, I have elected by my signature below to proceed with the removal against the Advice of Dr. Ehsani.

I am also aware that any balance on my account is due and payable in full within then (10) days of the date release.

Name(s) of patient/parent/Legal guardian _____

Signature _____ Date: _____

Witness _____

Signature _____ Date: _____