

# **Informed Consent for TMJ Orthopedic Repositioning Diagnostic Appliances**

**Diagnosis:** After a careful oral and facial examination, review of my dental models and photographs, radiographic evaluation and the study of my dental condition, I have been advised that I have Temporomandibular Dysfunction.

**Recommended Treatment:** In order to begin treatment of this condition, it has been recommended that I have a maxillary ( *upper jaw* ) or mandibular ( *lower jaw* ) Orthopedic Repositioning Diagnostic Appliance constructed to help determine the best lower jaw position in which I am comfortable. I understand that additional treatments may be required including, but not limited to, physical therapy, medical care and medications, chiropractic care, massage and/or trigger point injections. Additional dental consultations and x-rays may also be necessary.

I fully understand that the successful use of my Orthopedic Repositioning Diagnostic Appliance will help determine what final definitive dental treatment I will need, if any, to reposition my jaws in a more harmonious position with my body.

I am aware that after the three (3) to six (6) month diagnostic period is completed further treatment may involve the construction of a permanent TMJ appliance, crown and bridge reconstruction, dental orthopedic care and/or orthodontic treatment. Even with successful TMJ treatment, it is often recommended that most TMJ patients permanently wear a night time soft guard. I understand that further treatment is not included as part of the Orthopedic Repositioning Diagnostic Appliance therapy costs.

**Expected Benefits:** The purpose of wearing the Orthopedic Repositioning Diagnostic Appliance is to reduce symptoms, determine a comfortable position for my jaws and to restore function. I understand that each individual is unique and that I have not received any guarantees or assurances regarding anticipated results. If I do not accept management as recommended by the dentist, I understand that the problem(s) may continue to worsen.

**Principal Risks and Complications:** I am aware that I may initially experience discomfort while wearing my appliance and that my symptoms may actually get temporarily or permanently worse. I understand that there may be some minimal shifting of my teeth with prolonged wearing of appliances, particularly if I clench or grind my teeth. I am aware that wearing appliances long-term without professional supervision may be harmful. Splint therapy can cause changes in my bite and/or the way that my teeth and jaws fit together. My bite may change and my jaw may heal or become adjusted to a new position.

Some patients do not respond favorably to appliance therapy and require jaw or temporomandibular joint surgery.

I may require additional treatment ( Phase II ) to correct bite changes or to move my teeth into positions that match the new jaw position found to be more favorable from wear of my Orthopedic Repositioning Appliance.

**Alternatives to Suggested Treatment:** I understand that the alternatives to Orthopedic Repositioning Appliance Therapy are as follows:

1. No treatment
2. Permanently wearing a soft guard at night

**Necessary Follow-Up Care and Self-Care:** I fully understand and acknowledge that it is important for me to continue to see my dentist for routine dental care

I fully understand I need to come back for several post-operative visits so my progress may be monitored and so the dentist can evaluate and report on the outcome of treatment to any other doctors involved with my care.

I acknowledge that it is important to:

1. Abide by the specific prescriptions and instruction given
2. See the dentist for scheduled post-operative visits as needed

**No Warranty or Guarantee:** I acknowledge no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases tmj treatment goes well and without major incident. Due to individual patient differences, however, there can never be a certainty of success. There is a risk of failure, and complications such as those listed above, despite the best of care.

**Publication of Records:** I authorize photos, models, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry.

**Communication with my Insurance Company, My Dentist or other Dental/Medical Providers involved with my care:** I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, the dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my tmj treatment.

I understand that it is my responsibility to immediately seek attention should any undue or unexpected problems occur and to immediately notify this office if treatment can not be continued in a timely manor or if any appointment can not be kept. Absolute patient cooperation is absolutely necessary and mandatory with this treatment.

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of repositioning appliance therapy, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the repositioning appliance therapy as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist. I have read and understand this document before I signed it.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

