Crown Dental Studio

INFORMATIONAL INFORMED CONSENT
OCCLUSAL ADJUSTMENT AND SPLINT THERAPY

I UNDERSTAND that **OCCLUSAL ADJUSTMENT** and **SPLINT THERAPY** involves procedures to adjust the bite to enable the teeth to come together in the best configuration for that individual patient.

I understand that occlusal adjustment and/or splint therapy includes risks and unsuccessful results that may possibly occur even though the utmost care and diligence is exercised in this dental procedure.

I also understand that I have been given no promises or guarantees as to success or anticipated results. Possible risks and possible unsuccessful results which may occur are as follows:

1. **Grinding or Smoothing of teeth**: Many times teeth do not occlude or articulate as they should because of the alignment of the biting surfaces and/or cusps of the teeth. In order to adjust the biting surfaces or cusps of the teeth it may become necessary to grind or disk these surfaces to make the occlusion (bite) more uniform.

2. **Sensitivity of teeth:** As a result of the grinding or disking of the tooth biting surfaces or cusps, the teeth that are ground or disked may become somewhat sensitive. This sensitivity should gradually disappear in a relatively short period of time. However, in some cases where teeth are extremely sensitive or it is necessary to thin the enamel layer substantially, this sensitivity may persist for longer periods of time. If the sensitivity does not disappear, it is necessary to notify this office for an examination to determine whether or not further treatment is necessary.

3. **Necessity for crowns**: At times, if the occlusion (bite) is determined to be excessively out of balance, occlusal adjustment alone may not be accomplished merely by grinding or disking of the teeth because too much of the enamel surface would have to be removed which could lead to undesirable complications. In cases such as this, it may be necessary to crown the tooth or teeth to achieve a desirable articulation of the teeth for a more level bite.

4. **Splinting of teeth:** The placement of splints involves fabrication and placement of appliances to achieve a positioning of the upper and lower jaws in conjunction with their musculature to attain a comfortable meshing or alignment of the upper and lower teeth. Splints may also help to correct discrepancies in the bite which lead to a traumatic self-grinding or clenching of the teeth (uppers against lowers) which is called bruxism. Splints are often used in conjunction with occlusal adjustment procedures, particularly if the malocclusion (improper bite) is relatively severe.

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5. **Splinting and splints may be irritating and uncomfortable:** Splints fit over the teeth and may be uncomfortable or irritating to the tongue and other oral tissues. However, unless the splints are worn diligently, there is little or no chance for successful results. After splinting and depending upon the final position the jaws assume to reach a comfortable position it may be necessary to do extensive treatment to bring the occlusion (biting position of the teeth) into proper alignment. This might necessitate orthodontic treatment, crowns and bridges, surgery, periodontal treatment, etc. In many cases, referral to a specialist may become necessary in the attempt to achieve the desired results. During treatment, splints must be worn diligently and in strict compliance with instructions received from the treating dentist.

6. **Breakage of Splints**: Splints are constructed of plastic materials and for this reason it is possible for the splints to break, no matter how well they are constructed. Should breakage occur, it is necessary to have the splint repaired and reinserted as soon as possible to prevent a relapse in the treatment process.

7. **Termination of Splint Therapy**: Splints must be monitored over the period of time that they are worn by the patient. If a patient continues to wear a splint without having the bite checked at regular intervals by the attending dentist, it is possible that the bite may change to the point that further intervention in the form of orthodontic therapy or extensive crown and bridgework may become necessary. Splint therapy should be terminated unless the patient is willing to see the dentist for regular follow-up examinations.

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING THE NATURE AND PURPOSE OF OCCLUSAL ADJUSTMENT AND SPLINTS AND HAVE RECEIVED ANSWERS TO MY SATISFACTION. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH ANY PHASE OF THIS TREATMENT IN HOPES OF OBTAINING THE DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED. NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE PROGRESSION OR RESULTS OF THE TREATMENT. BY SIGNING THIS FORM, I AM FREELY GIVING MY CONSENT TO ALLOW AND AUTHORIZE CROWN DENTAL AND/OR THEIR ASSOCIATES TO RENDER ANY TREATMENT NECESSARY OR ADVISABLE TO MY DENTAL CONDITIONS, INCLUDING ANY AND ALL ANAESTHETICS AND/OR MEDICATIONS. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

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I HEREBY CONSENT AND AGREE TO RECEIVE THE FOLLOWING ALTERNATE TREATMENTS IN THE EVENT OF THE DESIRED RESULTS NOT BEING ACHIEVED:

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____
5. _____
   _____
   _____

PATIENT PARTICULARS:

FULL LEGAL NAME: _____

IDENTITY NUMBER: _____

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

Crown Dental Studio

Accepted and Signed at _____ on this _____ day of _____ 20_____

in the presence of the undersigned witnesses

_____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

Witnesses:

1. _____
   NAME:
   CONTACT NUMBER:
2. _____
   NAME:
   CONTACT NUMBER: