Crown Dental Studio

INFORMED CONSENT FOR THE TREATMENT OF TEMPOROMANDIBULAR JOINT AND OROFACIAL PAIN

With any medical or dental treatment, the success depends to a large extent in the degree of cooperation of the patient in following the prescribed treatment plan and keeping strategically scheduled appointments. Failure to comply with instructions and cancellations could delay the treatment time and seriously affect the success of the treatment.

Imaging is an important part of the diagnostic procedure and record keeping. Therefore, obtaining or taking the necessary images prior to treatment and during treatment may be indicated.

Your treatment may involve the fabrication and maintenance of various appliances that may cover either the upper or lower teeth. In addition, supplementary care may include various physical therapy modalities (at the office or by a physical therapist), trigger point injections, exercises, and various medications. Adjunctive care by other practitioners may be indicated. Since stress is commonly a contributing factor, stress management may also be indicated.

The purpose of this treatment is to relax various groups of muscles, to restore normal function as best as possible, and to provide a degree of pain relief. The treatment itself initially may include some discomfort. Not treating these conditions may cause perpetuation of symptoms with concomitant degenerative joint changes, alteration of tooth and muscle physiology and continued discomfort.

It is difficult to give guarantees or assurances of any sort as to the results that may be obtained. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, and work habits can affect the outcome and total resolution may not always be possible. Length of treatment may vary according to the complexity of your condition. If there is not an adequate initial response, further medical diagnostics may be requested. These fees will be in addition to those incurred.

As with any medical and dental treatment, unusual occurrences can and do happen. These possibilities can include minor tooth movement, loosened teeth or dental restorations, sore mouth, periodontal problems, muscle spasms, ear pain, and neck pain. For example, already loose fillings or crowns maybe loosened further while taking an impression during the course of treatment.

In the event the administration of anaesthetics such as injections are used, you should be aware that there may be side effects such as prolonged numbness of the area, nerve and tissue damage, hematomas, and discomfort following the procedures.

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There may be certain shifts in the position of your teeth or the relationship of one jaw to another. Depending on the nature of your original problem, these alterations of tooth or jaw position may not be reversible. Thus, additional care may be necessary, for example bite adjustment, braces, bridgework, etc.

Although any of the above mentioned complications may theoretically occur, they are rare and management of these issues will be explained as necessary at the time. In the above mentioned situations, additional dentistry may have to be performed by your dentist at your expense. Dr. Fareed Amod has explained to me the nature, purpose, benefits, risks, and alternatives to treatment.

Long term wearing of splints without professional guidance can be a detrimental situation. As long as the splint is being used, observation by our surgery is mandatory. The fees for these dental devices are for the impressions, bite registration and outside laboratory fabrication. Thereafter, there is a charge for each dental visit.

I UNDERSTAND THAT TREATMENT OF DENTAL CONDITIONS INCLUDES CERTAIN RISKS AND POSSIBLE UNSUCCESSFUL RESULTS, INCLUDING THE POSSIBILITY OF FAILURE. 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 HAVE GIVEN A COMPLETE AND TRUTHFUL MEDICAL HISTORY, INCLUDING ALL MEDICINES, DRUG USE AND PREGNANCY.

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

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. _____
   _____

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PATIENT PARTICULARS:

FULL LEGAL NAME: _____

IDENTITY NUMBER: _____

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

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: