NOVA Orofacial Pain, TMD & Dental Sleep Medicine

TMJ AND FACIAL PAIN CONSENT FORM

You may shortly begin your treatment. As part of this therapy, it is important to monitor you at regular intervals. Your scheduled appointments at our office are necessary for treatment to be successful. Cancellations are discouraged because of possible problems in the management of your case, and difficulties in rescheduling. 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 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. On the other hand, it is difficult to give guarantees or assurances of any sort as to the results that may be obtained. In the course of treatment, for example, during an impression, already loose fillings or crowns maybe loosened further. In those situations, dentistry will have to be performed by your dentist at your expense. Management of these issues will be explained as necessary at the time.

In the event the administration of anesthetics (injections) is 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.

If there is not an adequate initial response to this first phase, further medical diagnostics may be requested. These fees will be in addition to those incurred at this office.

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. It can be difficult to determine this until this treatment is completed.

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

PLEASE DISCUSS WITH THE DOCTOR ANY QUESTIONS OR RESERVATIONS YOU MAY HAVE ABOUT YOUR TREATMENT. THIS FORM MUST BE SIGNED BEFORE DEFINITIVE TREATMENT BEGINS.

I have read the above information and understand the course of treatment as proposed. Please sign and date below:

_____ _____

PATIENT/GUARDIAN DATE

Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Patient/Guardian Date