

Informed Consent Form for the Treatment of TMJ 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 at this office.

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 anesthetics 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.

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. Kim 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 office 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 office visit.

GOOD COMMUNICATION IS ESSENTIAL FOR SUCCESSFUL TREATMENT. PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS OR RESERVATIONS YOU MAY HAVE REGARDING YOUR PROBLEMS FOR TREATMENT. THIS FORM MUST BE SIGNED BEFORE TREATMENT BEGINS.

Informed Consent Form for the Treatment of TMJ and Orofacial Pain (2/2)

I have read the above information and understand the course of treatment as proposed. I realize that risks and limitations are involved. I do consent to treatment by Dr. Kim. Please sign and date below:

PATIENT/GUARDIAN

DATE

Notice of Privacy Practices Acknowledgment

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

PATIENT/GUARDIAN

DATE