

# INFORMED CONSENT FOR TMJ THERAPY

I request and authorize Janice J. Wilmot, D.M.D, M.S. P.C. to perform or assist in the performance of diagnosing and treating temporomandibular joint (TMJ or jaw joint) disorders and orofacial (mouth and face) pain.

I understand that diagnosis may involve a thorough history, physical examination, models of the teeth, x-rays, photos and diagnostic injections when necessary. If I accept the management program, treatment may include the wearing of a bite appliance, physiotherapy, exercise, medications, stress reduction and injections. Additional medical and dental consultations and x-rays may also be necessary.

The purpose of these procedures are to reduce symptoms 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 doctor, I understand that the problem(s) may continue to worsen.

I understand that management may involve the following risks: some discomfort after initial appliance insertion and after any injections, exercises, or physical therapy. I also understand that there may be some minimal shifting of teeth with prolonged wearing of appliances, particularly if I clench or grind my teeth. I also understand that long-term wearing of appliances without professional supervision may be harmful.

It is important for you to know that splint therapy may not be totally innocuous or simple. Splint therapy can cause changes in your bite or the way that your teeth and jaws fit together. The patient's bite or occlusion may change. The jaw may have healed or adjusted to a new position. As a result the patient may require additional treatment to correct these changes. The patient may require one of the following:

- 1) Simple equilibration or grinding or reshaping of the teeth to create a new harmonious tooth and jaw position.
- 2) If the new position is not attainable with equilibration, then orthodontic treatment (braces) for months or years may be required to correct the problem.
- 3) If the new jaw and teeth position is so unharmonious that equilibration or braces cannot correct the problem, then the patient may require jaw or jaw joint surgery.
- 4) As an alternative to the above, the patient may choose instead to have their teeth crowned or rebuilt by a dentist.
- 5) Any combination of the above.

In cases where steps 1-4 are not necessary splint therapy usually continues for a period of months. At the conclusion of the time period, if symptoms have improved, the patient may have several choices:

- 1) Continue to wear the splint on a permanent or semi-permanent basis and fees will then be based on a per visit fee for maintenance.
- 2) The patient may choose to have their teeth dentally rebuilt or orthodontically corrected or both.

I UNDERSTAND THAT I MAY REFUSE OR CONSENT TO ANY PROCEDURE SPECIFIED ABOVE OR DISCUSSED WITH ME. I am free to indicate at the bottom of this form anything not mentioned herein but to which I refuse to consent.

Under the doctor's supervision, an orthodontic assistant will assist the doctor in certain procedures and perform certain procedures within the scope of their training.

Your scheduled appointments at our office are necessary for management to be successful. Cancellations are discouraged because of the possible problems in the management of your case and difficulties in rescheduling.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACCEPT THE RISKS, IF ANY, IN HOPE OF OBTAINING THE DESIRED BENEFICIAL RESULTS. I HAVE BEEN FULLY INFORMED AND ALL MY QUESTIONS ABOUT TREATMENT AND ATTENDANT RISKS HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian)

Relationship to patient: \_\_\_\_\_

Signature of doctor: \_\_\_\_\_

Witness: \_\_\_\_\_

#### RECORDS RELEASE PERMISSION

I give Dr. Wilmot permission to use any of the diagnostic material, (photographs, models, x-rays, etc.) gathered from her examination and/or treatment of (patient) \_\_\_\_\_ in any form she may wish for the purposes of scientific education, teaching, and/or publications purposes.

\_\_\_\_\_  
Signature of parent/guardian Date: \_\_\_\_\_