Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

Purpose: This form is used to obtain acknowledgement of receipt of our Dental Materials Fact Sheet.

"I acknowledge that I have received from The Prosthodontic Dental Group, a copy of the Dental Materials Fact Sheet."

____________________________________ _______________

signature date

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement

"I have received a copy of this office's Notice of Privacy Practices."

____________________________________ _______________

signature date

Consent for the Use and Disclosure of Health Information

Purpose: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in out Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting your doctor.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation, submitted to your doctor. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

"I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that , by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations."

____________________________________ _______________

signature date

Name_______________________

The Prosthodontic Dental Group
Consent and Permit for Treatment

I hereby authorize Dr. Jeffrey Y. Nordlander, Dr. Brock E. Hinton, Dr. Barry B. Hoffman, Dr. Herlin K. Dyal and whomever they may designate as their associates, hygienists and assistants to perform upon ____ all necessary procedures and to administer anesthetics related to the examination, diagnosis, and treatment to be performed. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances.

Conservative therapy for TMJ is a method of treatment, which is successful for the majority of patients. However, success in some cases is only partial, or may fail to control the critical symptoms. When this occurs, other treatment such as surgery is sometimes indicated. If treatment succeeds in controlling the symptoms to a satisfactory degree, we must still remember that the structures are "WEAK" and may be a source of a potential trouble in the future. In addition, the treatment course may not show steady improvement. It is common for patients to have good and bad episodes during treatment until the final result is attained.

Cooperation and following instructions are essential to successful treatment. Failure to comply with your doctor's request may be damaging to jaw joints. This damage may make conservative treatment impossible. The patient must understand that other types of treatment may be necessary in conjunction with appliance therapy. Failure to comply and follow through with all recommended forms of treatment may lead to limited success or complete failure of treatment. This could cause the patient's condition to get worse.

A splint is a processed acrylic appliance, which feels very foreign when initially placed. Generally there is a sense of bulk and a variety of odd sensations that pass within a few days without great effort. The splint will also affect speech, causing distortion of some sounds. This again is a symptom, which generally passes within a week or so. You may be instructed to eat with your appliance. This is a difficult adjustment for most people to make but with perseverance it is possible and eventually eating can be done without effort.

The splint will increase plaque accumulation on your teeth. For this reason it is necessary to be extra thorough in your tooth brushing and flossing, especially around the tongue side of the teeth. When you clean your teeth, the splint should be brushed at the same time. Cleaning the splint with a toothbrush and toothpaste, or soap and water is an effective way of maintaining proper hygiene.

If it is necessary for you to wear your splint 24 hours a day and to eat with it, then repositioning of the lower jaw will probably occur. This is often a necessary process in the treatment of jaw joint problems. This change in position of the lower jaw results in alteration of the bite relationship between the upper and lower teeth. Generally there is a space that develops between the upper and lower teeth. Closing this space may require some form of dental treatment after control of the joint symptoms is achieved. The exact type of treatment needed varies from individual to individual, depending on the condition of the teeth and amount of change in the bite that has occurred. Treatment that is commonly necessary includes adjusting the bite by grinding the teeth, placing dental restorations such as crowns on some or all of the teeth, orthodontic care (braces), making new dentures or partials and orthognathic (jaw) surgery.

When treatment for jaw problems is needed but not carried out, there is potential for the problem to get worse. This may take the form of an increase in pain, joint symptoms such as clicking, popping and locking, future deterioration of the jaw joints and/or the disc in the joint, and an increase in

spasm and dysfunction of the head and neck musculature. Avoiding or postponing treatment may also compromise the result which otherwise might have been attained.

The nature, purpose, and risk of the procedures and possible alternative methods of treatment will or have been fully explained to me. I understand that there is a possibility of complications developing during or after any type of dental treatment. These include but are not limited to pain, numbness, tooth and soft tissue sensitivity, devitalization of teeth, infection, tissue recession, injuries to the soft issues which include lips, gums, cheeks, and tongue, fracture to teeth, damage to a healthy tooth, jaw joint pain/problems, allergic reactions to materials used in the temporary and final restorations, and allergic reactions to anesthetics, medications and materials used in diagnosis or treatment.

I understand that with appliance therapy it is probable that following the use of the appliance, future treatment will be required. This may include but is not limited to adjustment of the dentition, placement of crowns and bridges and/or removable prostheses, orthodontic treatment and procedures involving jaw surgery. In order to arrive at a final diagnosis, it may be necessary to be referred to other health care practitioners for further evaluation and treatment.

I understand that appliance therapy is a form of diagnosis and that an appliance is used as a diagnostic tool to help determine the role malocclusion plays in the overall problem.

I understand that appliance therapy may not help me at all and could even cause my symptoms to increase and my problem to get worse.

I have read the above and accept responsibility for these and/or any other complications which may arise or result during or following the procedures which are to be performed at my request. I have not been given, or received any guarantee as to results to be obtained. I am now giving my free and voluntary informed consent for treatment to be rendered. I agree that if I fail to follow through with all recommended treatment, my treatment can be discontinued at any time.

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Patient Signature

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Legal Guardian if patient is a minor

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Witness Date