TMD Informed Consent

Disorders of the Temporomandibular Joint can mimic other dental and medical problems. A proper diagnosis regarding head and neck pain is very important because serious medical problems such as vascular disorders, brain tumors, cervical disc disorders, etc. can produce symptoms similar to TMJ disorders. It is important to inform our office of any change in your health history form that was previously provided.

Length of treatment may vary according to the complexity of your condition. Treatment times may vary from the initial estimate. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits, and bite relationship affect the outcome and total resolution may not always be possible. Estimated time for treatment for phase one can be up to twenty-four (24) months. In general, the treatment plan will be more lengthy and complicated if the problems existed for a long time.

As with any medical and dental treatment, unusual occurrences can and do happen. These possibilities could include minor tooth movement, loosened teeth or dental restorations, sore mouth, periodontal problems, muscle spasms, ear pain, and neck pain. Any of the above mentioned complications are rare, but theoretically may occur.

Good communication is essential for successful treatment. Please feel free to discuss any questions you may have regarding your problems or treatment.

Referrals to other professionals, such as physical therapists, nutritionists, chiropractors, medical doctors, neurologists, or ear-nose-throat specialists may be indicated and necessary for successful treatment. In order to avoid set backs in your progress, do not seek out these services without Dr. Snyder's knowledge and approval! Dr. Snyder may be referring you for CAT scan imaging of the head and neck.

I consent to the taking of photographs and x-rays before, during and after TMJ treatment, as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for the use of these photographs, x-rays and records to be used for the purpose of research, education or publication in professional journals.

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 could delay the treatment time and seriously affect the success of the treatment.

I understand that an orthosis is only the first step to resolve my neuromuscular and TMD disorder. This treatment is mostly **irreversible** after 1 month and my options may be as follows:

The second phase of treatment will require one of the following procedures:

- Crown and/or bridge restorations (non-removable tooth replacement options) with or without implants (surgically implanted root replacements)
- Orthodontia (braces)
- Combination of crown and/or bridge restorations and orthodontia
- Removable partial or complete dentures with or without implants
- A semi-permanent orthotic

I certify that I have read or had read to me the contents of this form and do realize that risks and limitations are involved. I do consent to treatment by Dr. Beth L. Snyder.

Signature_____ Date_____
(Patient or Guardian if minor)

TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY _____

PHYSICIAN NAME & ADDRESS _____

_____ REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		**1-4**	**0-10**
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial Pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Muscle Soreness	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
Other - write in:	_____	____	____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:
_____
_____
_____
_____

Patient Signature _____ Date _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Blood thinners
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Pain medication
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

Other current medications: _____

MEDICAL HISTORY

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Blood pressure ☐ High ☐ Low
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Fibromyalgia
Y ☐ N ☐ Frequent snoring
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Injury to ☐ Face ☐ Neck ☐ Teeth ☐ Head ☐ Mouth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Meniere's disease
Y ☐ N ☐ Migraines
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Needing extra pillows to help breathing at night
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Radiation treatment
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Sleep Apnea
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Swollen, stiff or painful joints
Y ☐ N ☐ Teeth clenching or grinding
Y ☐ N ☐ Wisdom teeth extraction

Other medical history:
_____
_____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY: MILD	SEVERITY: MODERATE	SEVERITY: SEVERE	FREQUENCY: OCCASIONAL (MONTHLY OR LESS}	FREQUENCY: FREQUENT (WEEKLY)	FREQUENCY: CONSTANT (EVERY DAY)	DURATION: SECONDS	DURATION: MINUTES	DURATION: HOURS	DURATION: DAYS	DURATION: WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y ☐ N ☐ Motor vehicle accident
Y ☐ N ☐ Motorcycle accident
Y ☐ N ☐ Work related incident
Y ☐ N ☐ Playground incident
Y ☐ N ☐ Athletic endeavor
Y ☐ N ☐ Fight
Y ☐ N ☐ Fall
Y ☐ N ☐ Accident
Y ☐ N ☐ Illness
Y ☐ N ☐ Injury
Y ☐ N ☐ Unknown

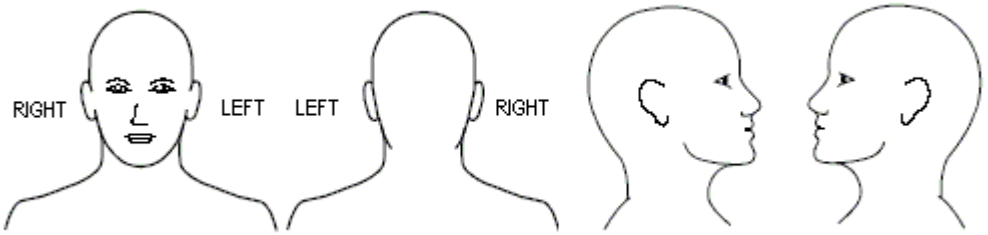
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

PATIENT PROGRESS REPORT

Form 201

Patient Name _____ Date _____

List any symptoms since your last visit that you want to bring to my attention _____

_____

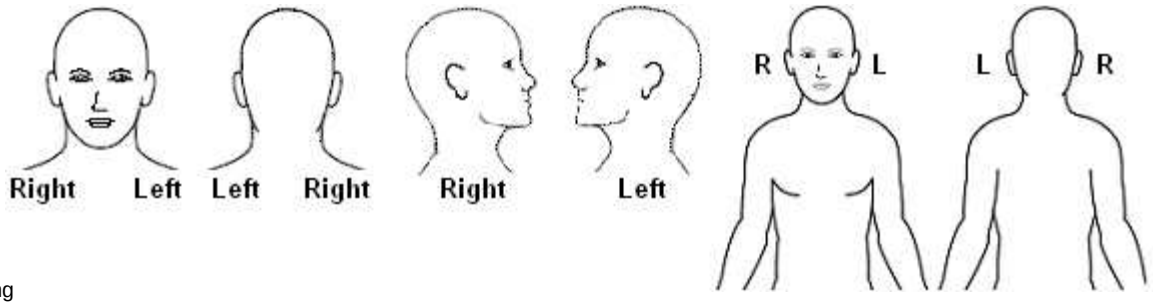
_____

DRAW YOUR CURRENT PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN

MODERATE PAIN

SEVERE PAIN



B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

DEGREE OF DISCOMFORT

Indicate your current degree of discomfort or pain level by circling the corresponding numbers below:

Chief Complaints	No Pain	Mild Pain				Moderate Pain		Severe			Worst Possible
☐ Back Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Dizziness	0	1	2	3	4	5	6	7	8	9	10
☐ Ear Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Ear Congestion	0	1	2	3	4	5	6	7	8	9	10
☐ Eye Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Facial Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Fatigue	0	1	2	3	4	5	6	7	8	9	10
☐ Headaches	0	1	2	3	4	5	6	7	8	9	10
☐ Inability to open mouth	0	1	2	3	4	5	6	7	8	9	10
☐ Jaw Clicking	0	1	2	3	4	5	6	7	8	9	10
☐ Jaw Joint Noises	0	1	2	3	4	5	6	7	8	9	10
☐ Jaw Locking	0	1	2	3	4	5	6	7	8	9	10
☐ Jaw Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Limited Mouth Opening	0	1	2	3	4	5	6	7	8	9	10
☐ Muscle Twitching	0	1	2	3	4	5	6	7	8	9	10
☐ Neck Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Pain when Chewing	0	1	2	3	4	5	6	7	8	9	10
☐ Ringing in Ears	0	1	2	3	4	5	6	7	8	9	10
☐ Shoulder Pain	0	1	2	3	4	5	6	7	8	9	10
☐ Sinus Congestion	0	1	2	3	4	5	6	7	8	9	10
☐ Throat pain	0	1	2	3	4	5	6	7	8	9	10
☐ Tinnitus	0	1	2	3	4	5	6	7	8	9	10
☐ Visual Disturbances	0	1	2	3	4	5	6	7	8	9	10
☐ Muscle Soreness	0	1	2	3	4	5	6	7	8	9	10

Patient Signature _____ Date _____

*** This Progress Report is to establish a baseline ***