Informed Consent for Patients Who Exhibit Symptoms of TMJ Disorder

Disorders of the temporomandibular joint can mimic other dental and medical problems. A recent medical examination by a physician should rule out life threatening diseases that can cause headaches including, but not limited to, such conditions as intracranial tumor or coronary heart disease. The patient can help by giving the clinician a detailed medical and family history, including a history of any food or drug allergies. Treatment for TMJ disorders can be lengthy and frustrating. The patient must inform the clinician about changes in jaw function.

Length of Treatment: Treatment time can vary widely. In general, the treatment plan will be more lengthy and complicated if symptoms are severe, or the problem has existed for a long time.

Possible Complications: We will make our best effort to diagnose and treat and TMJ disorder with timely and cost-effective methods. The most proven and conservative techniques will be used. However, you should be aware that there is much debate in the scientific literature on the most effective techniques or combination of treatments modalities. They include, but are not limited to, prosthetic splints, restorative dental procedure, TM joint surgery, biofeedback, phonophoresis, transcutaneous electrical nerve stimulation (TENS), acupuncture, muscle trigger point injections, hypnosis, psychological counseling, orthodontic and orthopedic appliances. Anytime a general anesthetic is used, the possibility of respiratory or cardiac arrest, allergic reaction, and death increases. As with any form of medical or dental treatment, infrequently, unusual occurrences can do and happen. Orthodontic, orthopedic, and prosthetic appliances may be swallowed or inhaled. Swallowed appliances may have to be surgically removed. Inhaled appliances can lead to respiratory arrest and death. Broken of loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root absorption, non-vital teeth, muscle spasms, ear and back problems, limb numbness, and additional medical and dental risks are all possible occurrences.

Some TMJ symptoms may get much worse with treatment. Patients with longstanding arthritic joint disease or traumatic injury can demonstrate more severe symptoms during the initial stages of treatment.

Good communication is essential for the best treatment results. Please call of come to the office if you have any questions regarding treatment.

I consent to the taking of photographs, video tapes, and x-rays before, during and after treatment.

I certify I have read or had read to me the consents of this form and do realize the risks and limitations involved, and do consent to the treatment by Dr. Christian Victor.

Patient Name:_____ Date:_____

Patient/Parent/Guardian Signature:_____

Witness:_____

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☐ Mulitple 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☐ Tooth 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

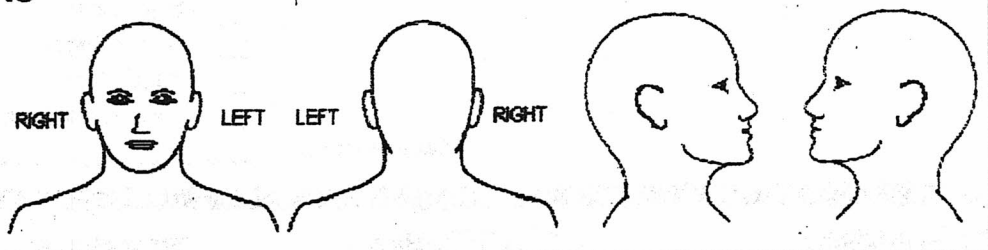
If accident, what was the date? _____

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 _____