Innovative Dentistry
Informed Consent for Night Guard
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I understand that an occlusal guard may minimize the possible harmful effects of occlusal habits including: sensitive teeth, worn teeth, cracked or fractured teeth. I also understand that the occlusal guard will not prevent my occlusal habits from continuing but rather introduce a protective material between my upper and lower teeth to minimize additional damage or symptoms of occlusal stress. It is only effective while it is being worn and provides no protection during times when it is not worn.

I have been informed that the symptoms I may currently have may be the result of occlusal habits. There may be other dental and systemic conditions that may be contributing to my symptoms. Further evaluation for other causes may be necessary.

I fully understand that an occlusal guard or splint of a more sophisticated design may be necessary in the future depending on my response and the durability of the material over time with my particular occlusal habits.

I have been informed that my condition can sometimes be treated simply over the short term or could require treatment over several years and could include orthodontic treatment, restoration with crowns, bridges, implants or surgery.

Longevity/replacement. The occlusal guard will/may require replacement if it is lost, damaged, worn or the underlying teeth are changed (with new fillings, crowns, bridge, etc.). Additional fees will apply if replacement is necessary.

FOR ALL PATIENTS I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I have been given the opportunity to ask questions about the Occlusal Guard and believe that I have sufficient information to give my consent as noted below.

CONSENT

I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

Patient Name:_____ Date:_____

_____ _____

Patient or Legal Guardian Signature Legal Guardian Printed Name