

**INFORMATIONAL USE ONLY**

**CONSENT TO OCCLUSAL EQUILIBRATION**

I (we) have sought or been referred to Dr. \_\_\_\_\_ for occlusal equilibration, which I (we) understand is a means of altering the bite or contact surfaces of some or all of my teeth, so that when my teeth come together, the jaw hinge, or temporomandibular joints, are in good anatomical position. I (we) fully understand the importance of the history which I (we) have given to the Doctor, which, together with his examination, indicates that my symptoms which I (we) have reported to the Doctor may be improved and may be eliminated. I (we) understand that the Doctor does not guarantee that by changing bite surfaces, any result is guaranteed, and in fact, I (we) have been informed by the Doctor that there are possible complications which, although not likely to occur, may occur, despite the exercise of the Doctor's greatest skill and care. These include: loss of some tooth enamel; the possibility that a tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; that a tooth or teeth may require rebuilding by removing even greater amounts of tooth structure and replacing it with a crown, which may be expensive. I (we) further understand that additional dental treatment may be required in the future terms of additional equilibration, and any and all additional recommended dental care and treatment as set forth by in the Doctor's treatment plan, if one has been discussed and agreed upon. I (we) further understand that if extensive equilibration is required, that there may be some change in the appearance of the teeth and mouth, and some increased sensitivity to temperature extremes. The Doctor has explained to me (us) that there are other approaches to therapy, such as: splint therapy, orthodontics, and orthographic surgery. I (we) understand that if any of these approaches were used, several hundred dollars of additional diagnostic aids would be necessary, namely: hinge axis location, pantographic surveys, equilibrated study casts and possibly transcranial radiographs and arthrography. Although all these options have been discussed and offered to me, I (we) have rejected them in favor of direct equilibration. Finally, I (we) have received literature explaining occlusal equilibration which has been read and understood.

I (we) fully consent to receiving occlusal equilibration from Dr. \_\_\_\_\_, and to pay all reasonable and necessary charges therefor which have been previously and fully explained to me (us).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Parent or Guardian (if applicable)