INFORMED CONSENT TO OCCLUSAL EQUILIBRATION

Selective reshaping of the chewing surfaces of teeth with the intention to reposition the mandible and stress relieve the muscle in the head and neck suspension apparatus

____ Direct Equilibration
____ Following Preconditioning Appliance Therapy

Patient: _____________________________ Dentist: _____________________________

I the undersigned have sought or have been referred to the above named Doctor for occlusal equilibration, which I understand is a means of altering the chewing surfaces of some or all of my teeth, so that when my teeth come together, the temporomandibular joints (jaw joints) are in good anatomical position. I fully understand the importance of the history which I have given to the Doctor, which, together with the Doctor’s examination indicated that the symptoms which I have reported to the doctor may be improved and may be eliminated.

I understand that the Doctor does not guarantee that by changing the chewing surfaces of my teeth that any result is guaranteed, and in fact, I 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 but are not limited to: loss of some tooth enamel; the possibility that 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; pain in the face and jaws; chewing difficulty; joint noise; and sensitive teeth.

I further understand that additional dental services may be required in the future such as additional equilibration and any and all additional recommended dental care and treatment as set forth in the treatment plan presented by the Doctor, if one has been discussed and agreed upon. I 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 that there are other approaches to therapy, such as: occlusal appliance therapy, orthodontics, reconstructive dentistry, and orthographic surgery. I understand that if any of these approaches are used, additional diagnostic aids and expense would be necessary. Although all these options have been discussed and offered to me, I have rejected them in favor of direct equilibration. Finally, I have received literature explaining occlusal equilibration which has been read and understood.

I fully consent to receiving occlusal equilibration from the Doctor and to pay all reasonable and necessary charges therefore which have been previously and fully explained to me.

________________________________ ________________________________
Date Signature

Doctor’s Agent Parent or Guardian (if applicable)