



## **Dr. Gregory Yount, DMD**

### **TMJ 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 disorder, brain tumors, aneurisms, cervical disc disorders, throat and oral cancer, etc. can produce similar symptoms of 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 therefore vary from estimates. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits, bite relationship, etc. do affect the outcomes and therefore, total resolution is not always possible. Estimated time for treatment depends on the severity of the case and how long the symptoms have existed.

The type of treatment methods we use are based on experience, skill, knowledge to be the most proven, appropriate, cost effective, and conservative. However, you should be aware there is much debate in the medical-dental community regarding the best methods of treating various TMJ disorders.

As with any medical or 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, neck pain, etc. Any of the mentioned complications are rare, but theoretically may occur. Additional medical and dental risks that have not been mentioned may occur. Dr. Yount has explained to me the nature, purpose, benefits, risks of and alternatives to neuromuscular/cranio-mandibular orthopedic treatment.

Good communication is essential to successful treatment. Please feel free to discuss any questions you may have regarding any problems or treatment. Referral to other professional, such as physical therapists, nutritionists, chiropractors, medical doctors, neurologists, or ear-nose-throat specialists may be indicated and necessary for successful treatment.

With any medical or dental treatment the success depends to a large extent on the degree of cooperation of the patient in following the prescribed treatment plan. Failure to comply with instructions will delay the treatment time and seriously affect the success of the treatment. I understand and acknowledge that routine hygiene care is essential during orthotic care in order to prevent any decay and/or periodontal problems. For a permanent solution, patients must be aware that a final finishing stage is usually required following Level II Diagnostic Orthotic Therapy.

The neuromuscular orthotic is not designed for long term use. If symptoms reoccur after the orthotic is removed, a Diagnostic Orthotic Therapy consultation appointment is scheduled with the patient to discuss future treatment options. This treatment may require one of the following:

- Crown and/or bridge restorations
- Orthodontia
- Combination of crown and/or bridge restorations and orthodontia
- A semi-permanent orthotic
- Removal partial dentures, dentures. provisional flipper or implant surgery

Treatment plans are estimates. The fee quoted is valid for 90 days from today's date. Payment is expected at the time of the first appointment. The fee quoted includes 3 follow-up adjustments. A \$500 fee is charged for any additional adjustment visit paid at time of appointment. A fee of \$5,000 is charged for any lost or broken orthotic or denture. Any medical reports are charged at \$500 per hour. Fees for permanent stabilization are based on current fees at the time of restoration.

Treatment cost (includes records and orthotic) is . Payment is expected in full at the first appointment.

The cost of this treatment includes but is not limited to the following:

**Level I**

- TMJ/TMD Exam and Evaluation
- Cone Beam Scan
- Tens/Bite Registration
- K-7 Scans

**Level 2**

- Orthotic Appliance

I certify I have read or had read to me the contents of this form and do realize risks and limitations are involved. I understand and agree to follow the protocol prescribed by Dr. Yount. I understand by not following the prescribed protocol, treatment may be discontinued, unsuccessful, and/or delayed. I understand I am responsible for any and all fees associated with treatment regardless of any insurance coverage. I understand the financial requirement and agree to pay all associated fees in full at the time of my first appointment. If additional treatment is required, I understand and agree to pay all the additional associated fees at the time of service.

I consent to treatment and the payment requirement and I authorize Dr. Gregory Yount, DMD to perform the above listed treatment.

\_\_\_\_\_  
Patient or responsible person

\_\_\_\_\_  
Date



**Gregory G. Yount  
225 Richmond Ave.**

**P.O. Box 1217**

**Mattoon, IL 61938**

**(217) 235-0434**

### **Musculoskeletal Screening Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas. (L=Left; R=Right, Y= Yes; N=No)

- |                       |     |                                    |     |
|-----------------------|-----|------------------------------------|-----|
| 1. Pain in jaw joints | L R | 17. Headache (Tension or Migraine) | L R |
| 2. Pain in ear        | L R | 18. Fullness, pressure, stuffiness |     |
| 3. Pain around eyes   | L R | &/or blockage in ear               | Y N |
| 4. Pain in lower jaw  | L R | 19. Pain in tongue                 | Y N |

- |   |   |   |                                     |   |   |
|---|---|---|-------------------------------------|---|---|
| 5. Pain in upper jaw                      | L | R | 20. Partial inability to open mouth | Y | N |
|   |   |   | If yes:                             |   |   |
|   |   |   | Constant                            | Y | N |
|   |   |   | Sporadic                            | Y | N |
| 6. Pain in the neck                       | L | R | 21. Difficulty chewing              | Y | N |
| 7. Pain in shoulder                       | L | R | 22. Difficulty swallowing           | Y | N |
| 8. Pain in forehead                       | L | R | 23. Constantly tired or Insomnia    | Y | N |
| 9. Pain in temples                        | L | R | 24. Loud snoring                    | Y | N |
| 10. Pain in facial muscles                | L | R | 25. Mouth breathe at night          | Y | N |
| 11. Grating sound in joint                | L | R | 26. Awaken with dry mouth           | Y | N |
| 12. Difficulty with hearing               | L | R | If yes:                             |   |   |
|   |   |   | Frequently                          | Y | N |
|   |   |   | Rarely                              | Y | N |
| 13. Clicking or popping<br>sound in joint | L | R |                                     |   |   |
| 14. Dizziness (vertigo)                   | Y | N |                                     |   |   |
| 15. Upset stomach-nausea                  | Y | N |                                     |   |   |

27. What are your chief complaints? Please list complaints from the most to least important.

- \_\_\_\_\_  
  —
- \_\_\_\_\_  
  —
- \_\_\_\_\_  
  —

28. List additional symptoms?

\_\_\_\_\_

- |  |     |        |     |       |
|--|-----|--------|-----|-------|
| 29. Do symptoms affect one or both joints?           | L   | R      | or  | Both  |
| 30. If both joints, which one is most affected?      | L   | R      |     |       |
| 31. How long have you been bothered by this problem? | ___ | Days   | ___ | Weeks |
|  | ___ | Months | ___ | Years |
| 32. Have you had any injury to the jaw or face?      | Y   | N      |     |       |

If so, please briefly explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- |   |   |   |
|---|---|---|
| 33. Do you have arthritis?                | Y | N |
| 34. Have you ever had general anesthesia? | Y | N |

- 35. Have you ever had cervical traction? Y N
- 36. Have you ever worn a neck brace? Y N
- 37. Have you had your teeth straightened? (Orthodontia) Y N
- 38. Have you had your wisdom teeth removed? Y N
- 39. Did you have allergies as a child? Y N
- 40. Have you had your bite adjusted by a dentist (equilibrated)? Y N

If yes, please explain when and why: \_\_\_\_\_

\_\_\_\_\_

- 41. Do you clench your teeth? Y N
- 42. Do you grind your teeth (Brux) at night during your sleep? Y N
- 43. Do you chew gum? Y N

Frequently \_\_\_\_\_ Infrequently \_\_\_\_\_ Moderately \_\_\_\_\_ Never \_\_\_\_\_

- 44. Do you attribute the symptoms to one incident? Y N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

- 45. Have you had cortisone injected into the jaw joint? Y N

If yes, When \_\_\_\_\_ How many injections? \_\_\_\_\_

By Whom: \_\_\_\_\_

- 46. Have you had any other treatment for any of the above issues? (Medical, exercise, dental appliances splint or night guard). \_\_\_\_\_

\_\_\_\_\_

- 47. List all medications and dosage taken for these issues: \_\_\_\_\_

\_\_\_\_\_

- 48. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related issues.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 49. Please indicate any other pertinent information which has not been covered previously.

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50. Are you in litigation or are you planning litigations? If so, please explain:

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Date Completed: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_