

## Consent for Occlusal Equilibration

### What is Occlusal Equilibration and its benefits?

Occlusion (or biting) is the result of all components used in bringing teeth together. These components include the TMJ joints, the biting muscles, the upper and lower jaws, gums and teeth. The resulting bite or occlusion can become misaligned when any one of these components are outside of their normal limits. When this happens it results in pain, abnormal wear on teeth and restorations or broken teeth and restorations. Occlusal equilibration is the altering of the biting surfaces of teeth with the intent to place them back to a normal position. How they got out of position is usually due to the accumulation of several fillings, crowns and bridges, having teeth extracted, orthodontics, developmental defects, trauma, and clenching or grinding habits.

### What are the risks?

1. The bite feels different: This is normal and you will gradually accept this as your new bite
2. Reduction in tooth or restoration surface: When adjusting the biting surfaces, it is necessary to grind off the offending areas of enamel or restorative material. This is minimal in most areas.
3. Restorative care needed afterwards: If one or more teeth are severely out of alignment more aggressive adjusting will be necessary. This could result in the tooth needing a restoration in the form of a filling, onlay or crown. Existing dental work may need to be replaced as well.
4. Sensitive teeth: After adjustments the teeth may become sensitive. Topical application of a desensitizing gel can alleviate most symptoms. However, restorative care may be needed in the form of a filling, onlay, crown or root canal.
5. Occlusal guard may be needed: After equilibration it may become necessary to wear an occlusal guard (bite splint) to continue protecting the teeth and it's bite.

### What are my alternatives?

Considering the components used in creating a bite, altering other variables may be used. They include occlusal appliance therapy, orthodontics, reconstructive dentistry, and orthognathic surgery. After equilibration these other approaches may be necessary.

**INFORMED CONSENT:** I can read and write English and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, which may be associated with any phase of this treatment in hopes of obtaining the desired result. The fees for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize the doctors and staff at Cross Timbers Dental in rendering any services they deem necessary or advisable to treat my dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications.

**Anesthetic:** The use of local anesthetic is used for pain control during dental procedures. There are inherent risks and side effects. They include, but not limited to: swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction, and altered sensation that may lead to self-injury. Partial or complete numbness may linger after the dental appointment. In rare cases it can last for an extended time and potentially it can be permanent.

**Medications:** Any medications dispensed or prescribed are the patient's responsibility to understand before taking. Medication inserts are available from our office upon request. Particular attention should be given to possible allergic reactions, drug interactions with current medications and their specific side effects.

**Guarantees:** The practice of dentistry is not an exact science and no procedure is 100% successful. The doctors and/or staff at Cross Timbers Dental have made no guarantees of a successful outcome.

**Notifications:** If a patient develops a problem it is the patient's responsibility to notify the doctors and/or staff of Cross Timbers Dental. Through this notification we will be able to act on the patient's behalf. Attempts to correct a problem may occur at our office or a referral to another health care practitioner may be warranted.

Patient's name (please print) \_\_\_\_\_

Signature of patient/legal guardian \_\_\_\_\_

Date \_\_\_\_\_