Consent Form for the Use of Occlusal Splint or Mouth Guard

PSU Dental Hospital

I, Mr./Mrs./Ms....., Age: ..... years old,
As: ☐ The patient, HN: .....
☐ The authorized representative of the patient, Name: .....
Relationship to the patient: .....

1. I voluntarily consent to allow the assigned dentist and hospital staff to be involved in my care. I have been informed and understand my condition, which includes:

☐ Temporomandibular joint disorder and masticatory muscle disorder ☐ Sleep Bruxism
☐ Use of a mouth guard for sports

2. I understand and consent to the treatment plan proposed for me, which includes:

☐ Guidance on jaw exercises and care ☐ Medication ☐ Hard occlusal splint
☐ Soft occlusal splint ☐ Physical therapy
☐ Trigger point injection ☐ Acupuncture ☐ Cognitive-behavioral therapy (CBT)

3. I acknowledge the treatment details, including possible side effects, such as:
1. Slight changes in bite alignment 2. Tooth soreness 3. Temporary excessive saliva production If untreated, the condition may lead to:
1. Chronic jaw pain 2. Severe tooth wear or fracture. 3.TMJ degeneration
(Additional explanations, if any: .....)

4. After receiving the occlusal splint, I should follow up with my dentist as scheduled.

5. Treatment costs:
I acknowledge and accept the treatment costs, which include procedure or device .....
..... Price: ..... Baht
(In words) ..... Baht
Fees are based on the latest updated rates of the Faculty of Dentistry, Prince of Songkla University Dental Hospital.

6. I voluntarily consent to allow the assigned dentist and hospital staff to participate in my care. I also authorize necessary additional procedures deemed beneficial for diagnosis or treatment, such as radiographic examination, blood tests, or allergy testing (specify if applicable):
.....
.....

I willingly consent to receive the stated treatment.

Signature:	Signature: .....
(.....)	(.....)
Treating Dentist	Patient / Authorized Representative Relationship to the patient: .....
Signature:	Signature: .....
(.....)	(.....)
Witness	Witness Date: ..... Time: .....

Note:
1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.