Consent Form for Oral Appliance Use
for the Treatment of Snoring and Obstructive Sleep Apnea

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: .....

I voluntarily consent to allow the dentist and assigned hospital staff to participate in my care. I have received explanations and information regarding my condition as follows:

1. Facts for Consideration

Snoring and/or obstructive sleep apnea (OSA) can negatively impact health by causing incomplete or restless sleep, low blood oxygen levels, excessive daytime sleepiness, irregular heart rate, and high blood pressure. It also increases the risk of heart disease, hypertension, and stroke.

2. Benefits of Treatment

The use of an oral appliance helps improve breathing by advancing the jaw and tongue to widen the airway, thereby reducing snoring. Oral appliances have been effective for many patients; however, individual responses may vary due to different contributing factors. It may take time and adjustments to achieve optimal results.

3. Risks of Treatment

Potential side effects of using an oral appliance include excessive saliva production, difficulty swallowing, temporomandibular joint (TMJ) pain, tooth and gum soreness, dry mouth, tooth mobility, changes in occlusion, and possible loosening of defective dental restorations. Most side effects improve over time.

Long-term effects may include changes in occlusion, which could be reversible upon discontinuation of the appliance. Regular follow-ups with the dentist are essential for monitoring and adjustments. If any unlisted side effects occur, discontinue use and consult the dentist as scheduled.

4. Alternative Treatment Options

Other treatment options include lifestyle modifications, weight loss, continuous positive airway pressure (CPAP) therapy, and surgical interventions. You have chosen oral appliance therapy with the understanding that it may not fully resolve snoring or OSA. You must report any side effects and discuss concerns with your treating dentist.

5. Treatment Costs

I acknowledge and accept the treatment costs, which include the fabrication of oral appliance ..... at price of ..... THB (in words) ..... This fee is based on the latest pricing of the Faculty of Dentistry, Prince of Songkla University Dental Hospital.

6. Patient Decision

I have read and understood the information provided by the dentist, asked relevant questions, and comprehended the associated risks. From the above statement, I have received sufficient in formation and agree to undergo the 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.