**MODEL**

**INFORMED CONSENT FOR TEMPORARY ORAL APPLIANCE USE**

You have been diagnosed by your medical provider as requiring treatment for a sleep-related breathing disorder, such as snoring or obstructive sleep apnea (referred to as OSA). OSA may pose serious health risks if left untreated because it disrupts normal sleep patterns and can reduce normal blood oxygen levels. OSA may increase your risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

**ORAL APPPLIANCE THERAPY (OAT)**

An oral appliance is an FDA-cleared, retainer-like, custom device that fits over your teeth and is worn whenever you sleep. Oral appliances keep your tongue and jaw in a forward position, which helps keep your upper airway open. Oral appliances are designed to help reduce or eliminate snoring and interruptions to your breathing patterns while you sleep. Your appliance should be worn the entire time you sleep, with a recommended minimum use of 7 hours per day.

**TEMPORARY ORAL APPLIANCE THERAPY**

It is recommended that a temporary oral appliance be used for a brief period of time until the recommended use of your custom device begins. The goal of temporary oral appliance therapy (OAT) is relief from your snoring or OSA symptoms, more restful sleep, decreased daytime fatigue, and improved blood oxygen levels during sleep. A temporary oral appliance provides some of the benefits of OAT on short term basis. Temporary appliances are not custom-made and are not covered by medical or dental insurance and should only be used on a temporary, short-term basis as advised by your dentist.

**LENGTH OF TREATMENT USING TEMPORARY ORAL APPLIANCE:** The appliance you are being provided with today is for temporary use prior to the custom-fabricated appliance prescribed for you. It should be used every time you sleep for no more than \_\_\_\_\_\_ months.

**POTENTIAL SIDE EFFECTS**: Though uncommon, potential side effects may include, without limitation, discomfort to the jaw, muscle pain, irritation to the teeth, gums or tongue, broken or loosened teeth, excessive saliva, dry mouth, dislodged dental restorations, mouth sores, periodontal problems, root resorptions, non-vital teeth, muscle spasms, and ear problems. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call our office right away with questions or concerns.

By signing in the space indicated below, I understand and agree that:

* I am receiving a temporary oral appliance, intended for short term use until my custom-made appliance is fabricated and delivered.
* In the event of any discomfort, pain, breakage of the temporary oral appliance or other problem, cause, concern or issue causing me to stop using the temporary oral appliance, I will immediately contact my dental provider.
* I will notify this office and my dental provider (identified below) of any changes to the temporary appliance, my teeth, or my medical condition(s) or in the event I stop using this temporary appliance for any reason prior to receiving my custom oral appliance.
* I consent to short-term treatment with a temporary appliance to be delivered and adjusted by my dental provider (identified below) and agree to follow all post-delivery and homecare instructions.

I represent, warrant, and agree that I (i) have read (or had read to me) and understand this Consent Form; (ii) accept all risks and limitations inherent in the use of my temporary oral appliance; (iii) hereby consent to temporary oral appliance treatment; and (iv) have had the opportunity to ask questions and receive answers from my dental provider (identified below) and this office.

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| Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dentist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

**DISCLAIMER: The following Model AADSM Temporary Oral Appliance Informed Consent (“Consent”) was developed by AADSM members for informational and educational purposes only and is intended solely to serve as a resource to AADSM members. AADSM is not undertaking to render specific professional or legal advice. AADSM does not “approve”, “endorse” or otherwise support the use of the Consent or the information included therein.**

**The Consent does not take into account (nor comply with) applicable state, local or other statutes, regulations or laws. Accordingly, the Consent will not (and does not proport to) protect dentists from liability, generally, for malpractice or negligence in the performance of medical/dental services. What constitutes “informed consent” is governed by the statutes and case law of the individual states where the dentist practices.**

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