



SARAH SCHMIDT ELLIS, DMD

General and Cosmetic Dentistry

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of muscles. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in the muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntarily when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain - pain felt in another part of the body or in the teeth. Scar tissue and loss of range of motion and weakness may form over time. A small needle is inserted into the trigger point and a local anesthetic (e.g., lidocaine, procaine), botulinum toxin (e.g. Botox) or anti-inflammatory steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold, and an individualized medication program.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate additional surgery, prolonged hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The lung (or the pleura, which is the surrounding membrane) may be punctured if the procedure is performed in a muscle near the ribcage; and 7. The procedure may fail to reduce the pain symptoms. **Initial** _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to lidocaine, botulinum toxin or to human albumin. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____



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PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT:

I understand that I have the right to discontinue treatment at any time. **Initial** ____

TRAINING COURSE

I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment.

Initial ____

I hereby indemnify the American Academy of Facial Esthetics LLC from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial** ____

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial** ____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** ____

RESULTS

You may receive the following benefits. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are worth the risk. Trigger point injections is used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although there is some debate over its effectiveness. Many muscle groups, especially those in the arms, legs, lower back, and neck, are treated by this method. Trigger point injections can also be used to treat fibromyalgia, tension headaches, TMJ dysfunction, and other types of orofacial pain.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Patient Name (Print)

Patient Signature

Date



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I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)

Doctor Signature

Date