FoxViewDental

Cosmetic | Restorative | Implant | Sedation

Green Bay's Smile Maker

Botox PRE - TREATMENT INSTRUCTIONS

In an ideal situation it is prudent to follow some simple guidelines before treatment that can make all the difference between a fair result or great result, by reducing some possible side effects associated with the injections. We realize this is not always possible; however, minimizing these risks is always desirable.

- Patient must be in good health with no active skin infections in the areas to be treated
- Patient should not be needle phobic
- Avoid alcoholic beverages at least 24 hours prior to treatment Alcohol may thin the blood which will increase the risk of bruising.
- Avoid anti-inflammatory / blood thinning medications ideally, for a period of two (2) weeks before treatment. Medications and supplements such as Aspirin, Vitamin E, Gingo Biloba, St. John's Wort, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS are all blood thinning and can increase the risk of bruising/swelling after injections.
- Schedule Botox® appointment at least 2 weeks prior to a special event which may be occurring, i.e., wedding, vacations, etc. It is not desirable to have a very special event occurring and be bruised from an injection which could have been avoided.

INFORMED CONSENT FOR TRIGGER POINT THERAPY

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.

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I also understand Fox View Dental will not bill procedures to insurance. **Initial** ____

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** ____

RIGHT TO DISCONTINUE TREATMENT:

I understand that I have the right to discontinue treatment at any time. **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. I hold the Fox View Dental, S.C. 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

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

TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth/Age: _____

Sex: M or F (circle one) SSN or SIN: _____

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____

CHIEF COMPLAINT(S)

1) Describe what you think the problem is: _____

2) What do you think caused this problem? _____

3) Describe, in order (first to last), what you expect from your treatment: _____

_____

MEDICAL AND DENTAL HISTORY

1) Are you presently under the care of a physician or have you been in the past year? Yes ☐ No ☐

Physician's name: _____ Condition(s) treated: _____

_____

TREATMENT

Name of medication(s) you are currently taking: _____

_____

2) How would you describe your overall physical health? (circle one) Poor Average Excellent

3) How would you describe your dental health? (circle one) Poor Average Excellent

Dentist's name: _____ Date of last appointment: _____

4) Have you had any major dental treatment in the last two years? (circle one) Yes ☐ No ☐

If yes, please mark procedure(s): Orthodontics ☐ Periodontics ☐ Oral Surgery ☐ Restorative ☐

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

HISTORY OF INJURY AND TRAUMA

1) Is there any childhood history of falls, acidents of injury to the face of head? Yes ☐ No ☐

Describe: _____

2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)

Yes ☐ No ☐ Describe: _____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)

Yes ☐ No ☐ Describe: _____

FACIAL PAIN PAST TREATMENT

1) Have you ever been examined for a TMD problem before? Yes ☐ No ☐

If yes, by whom? When? _____

2) What was the nature of the problem? (Pain, noise, limitation of movement): _____

_____

3) What was the duration of the problem? Months? Years? _____

Is this a new problem? Yes ☐ No ☐

4) Is the problem getting better, worse or staying the same? _____

5) Have you ever had physical therapy for TMD? Yes ☐ No ☐ If yes, by whom? When? _____

_____

6) Have you ever received treatment for jaw problems? Yes ☐ NO ☐ If yes, by whom? When? _____

_____

What was the treatment? (Please mark Below)

Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics

Counseling Surgery

Other ☐ (Please explain): _____

7) Have you ever had injections for your TMD with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories?

Yes ☐ No ☐ If yes, were they effective? Yes ☐ No ☐

How many dental appliances have you worn? _____

8) Were these appliances effective? Yes ☐ No ☐

11) Is there any additional information that can help us in this area? _____

CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)

- ☐ Death of a Spouse
- ☐ Major Illness or Injury
- ☐ Major Health Change in Family
- ☐ Business Adjustment
- ☐ Divorce
- ☐ Pending Marriage
- ☐ Financial Problems
- ☐ Pregnancy
- ☐ Career Change
- ☐ Fired from Work
- ☐ Marital Reconcilliation
- ☐ Debt
- ☐ Death of a Family Member
- ☐ New Person Joins Family
- ☐ Marital Separation
- ☐ Other

CURRENT AND PREVIOUS HABITS (PLEASE MARK YOUR ANSWER TO EACH QUESTION)

1) Do you clench your teeth together under stress?.....Yes ☐ No ☐ Don't Know ☐

2) Do you grind/clench your teeth at night?.....Yes ☐ No ☐ Don't Know ☐

3) Do you sleep with an unusual head position?.....Yes ☐ No ☐ Don't Know ☐

4) Are you aware of any habits or activities that may aggravate this condition?.....Yes ☐ No ☐ Don't Know ☐

Describe: _____

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)

A. HEAD PAIN, HEADACHES, FACIAL PAIN

Forehead L R

Temples L R

- ☐ Migraine Type Headaches
- ☐ Cluster Headaches Maxillary Sinus
- ☐ Headaches (under the eyes)
- ☐ Occipital Headaches (back of the head with or without shooting pain)
- ☐ Hair and/or Scalp Painful to Touch

B. EYE PAIN / EAR ORBITAL PROBLEMS

- ☐ Eye Pain - Above, Below or Behind
- ☐ Bloodshot Eyes
- ☐ Blurring of Vision
- ☐ Bulging Appearance
- ☐ Pressure Behind the Eyes
- ☐ Light Sensitivity
- ☐ Watering of the Eyes
- ☐ Drooping of the Eyelids

C. MOUTH, FACE, CHEEK & CHIN PROBLEMS

- ☐ Discomfort
- ☐ Limited Opening
- ☐ Inability to Open Smoothly

D. TEETH & GUM PROBLEMS

- ☐ Clenching, Grinding at Night
- ☐ Looseness and/or Soreness of Back Teeth
- ☐ Tooth Pain

E. JAW & JAW JOINT (TMD) PROBLEMS

- ☐ Clicking, Popping Jaw Joints
- ☐ Grating Sounds
- ☐ Jaw Locking Opened or Closed
- ☐ Pain in Cheek Muscles
- ☐ Uncontrollable Jaw/ Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

- ☐ Hissing, Buzzing, or Ringing Sounds
- ☐ Ear Pain without Infection
- ☐ Clogged, Stuffy, Itchy Ears
- ☐ Balance Problems – "Vertigo"
- ☐ Diminished Hearing

G. NECK & SHOULDER PAIN

- ☐ Arm and Finger Tingling, Numbness, Pain
- ☐ Reduced Mobility and Range of Motion
- ☐ Stiffness
- ☐ Neck Pain
- ☐ Tired, Sore Neck Muscle
- ☐ Back Pain, Upper and Lower
- ☐ Shoulder Aches

H. THROAT PROBLEMS

- ☐ Swallowing Difficulties
- ☐ Tightness of Throat
- ☐ Sore Throat
- ☐ Voice Fluctuations

I. OTHER PAIN

_____

_____

_____

_____

_____

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED

NO PAIN MODERATE PAIN SEVERE PAIN

1) Degree of current TMD pain: 0 1 2 3 4 5 6 7 8 9 10

2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually After Eating

Is the pain constant, continuous, or intermittent? _____ How long does it last? _____

What is the quality of the pain? Sharp, dull, burning, aching, electircal, etc. _____

What makes it worse? _____

What makes it better? _____

How often does the pain occur? _____

Does the pain occur on it's own or do you need to trigger with function, touching, etc.? _____

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? _____

_____

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? _____

_____

3) Are you taking medication for the TMD problems? Yes ☐ No ☐ If so, what type? _____

_____

How long? _____ Who prescribed the medication? _____

4) Are the medications that you take effective? Yes ☐ No ☐ Conditional? _____

5) Are you aware of anything that makes your pain worse? Yes ☐ No ☐ If yes, what? _____

_____

6) Does your jaw make noise? Yes ☐ No ☐ If so, when and how? _____

Right ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

Left ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

7) Does your jaw lock open? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

8) Has your jaw ever locked closed or partly closed? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

9) Have any dental appliances been prescribed? Yes ☐ No ☐

If yes, by whom? _____

When? _____ Describe: _____

When do you wear your dental appliances? _____