ORAL APPLIANCE FITTING PROCEDURE CONSENT FORM

Date:_____Time:_____am/pm

1. I consent to the performance of the **SomnoGuard $_{AP2}$ Mandibular advancement Device (Oral Appliance) fitting procedure** upon _____.
(Name of patient)

The purpose of this procedure is to stabilize and advance the Mandible and associated musculature (including the base of tongue) to help maintain an open and patent airway while sleeping, and will be performed by_____ and whomever (s)he may designate as assistants.

2. The nature and purpose of the procedure, the benefits and risks of the procedure, the possibilities of complications and the alternatives to this procedure, their risks and benefits have been explained to me. These include but are not limited to, irritation or scalding of the gums, tooth and muscle discomfort, potential tooth movement, changes, wear or dislodging of prior dental work, occlusal changes and TMJ disorders.

3. It has been explained to me that a satisfactory result is expected, but that the following are some of the complications or effects that could or may occur: muscle and dental soreness, movement of teeth, hyper-salivation, dry mouth, and recurrence of symptoms.

4. No guarantee or assurance has been given by anyone about the results that may be obtained.

5. I understand that there will likely be the need to adjust the advancement of the appliance over time and that the device may require refitting in the event that it does not provide adequate retention, either immediately or in the future.

6. I consent to the doctors performing whatever different or additional operations or procedures they deem necessary or advisable during the course of the procedure.

7. I understand the device has a finite lifespan and will need scheduled replacement. The typical lifespan is 1-2 years, but can be substantially shortened by lack of care or grinding of teeth (bruxism) that I may or may not be aware of.

8. I understand it is my responsibility to maintain the device according to the instructions for use. As the device has a finite lifespan, I will inspect the device before each use and will discontinue use if material separation, degradation or cracks are found.

9. I do not have allergies or intolerance to anything except_____.

I have read and understand the content of this form and have received a copy.

_____
Witness to signing Patient, parent or person authorized to sign for patient (please print)

_____ _____
Physician's signature Signature of patient, parent or person authorized to sign for patient