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Temporomandibular Disorders (TMD)

(Please Print Legibly)

Patient Name: _____ Date: _____

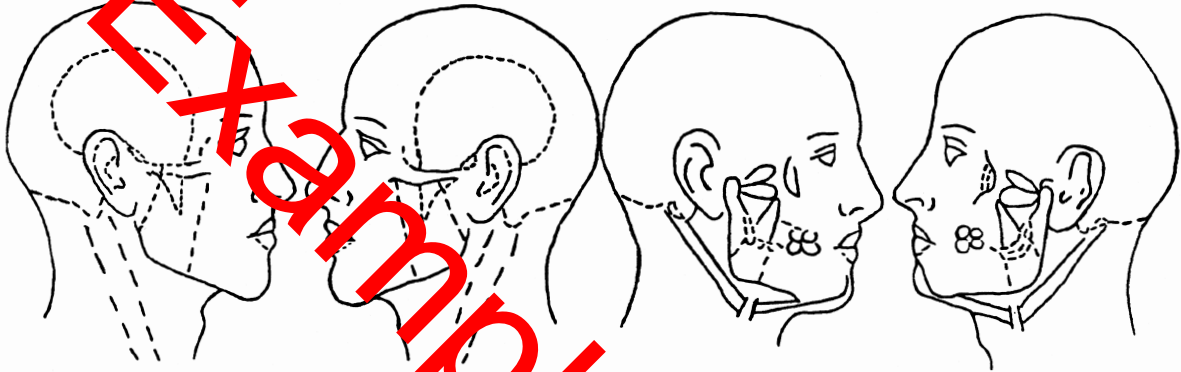
Referred by: _____

A. Symptoms & signs

1. Patient's Statement of the Problem

Main Complaint: _____

Patient's Comments: _____



2. Medical Complications: NONE

What? _____

3. Surgery: NONE

What? _____

4. Trauma: NONE

What? _____

5. Nature of Pain: NONE Mild Moderate Severe | Acute Chronic

6. Location of Pain:

RIGHT	LEFT		
<input type="checkbox"/>	<input type="checkbox"/>	a. TMJ	i. Neck: _____
<input type="checkbox"/>	<input type="checkbox"/>	b. Ears	
<input type="checkbox"/>	<input type="checkbox"/>	c. Masseters	j. Shoulders: _____
<input type="checkbox"/>	<input type="checkbox"/>	d. Temporals	
<input type="checkbox"/>	<input type="checkbox"/>	e. Sternomastoid	k. Back: _____
<input type="checkbox"/>	<input type="checkbox"/>	f. Occipital	
<input type="checkbox"/>	<input type="checkbox"/>	g. Ext. Pterygoid	
<input type="checkbox"/>	<input type="checkbox"/>	h. Int. Pterygoid	l. Other: _____

7. Tooth Pain: NONE

Location: _____

Stimulated by What? _____

Temporomandibular Disorders (continued)

B. Clinical exam

1. MANDIBULAR OPENING

- a. _____ mm (maxillary central to mandibular central)
- b. Movement to right _____ mm. Movement to left _____ mm.
- c. Deviations: to right to left
- d. Painful: No Yes; Where? _____

2. STETHOSCOPE

- a. Right joint: Normal Clicking Crepitus
- b. Left joint: Normal Clicking Crepitus

3. OTOSCOPE:

- a. Right ear: Normal Inflammation Wax Other: _____
- b. Left ear: Normal Inflammation Wax Other: _____

4. RADIOGRAPHS: Type: _____

- a. Right joint pathosis: _____
- b. Left joint pathosis: _____
- c. Other: _____

5. OCCLUSION: Angle: _____

- a. Centric relation first tooth contact: _____
- b. Centric relation to centric occlusion shift: _____
- c. Centric relation to maximum intercuspal position shift: _____
 Forward to left to right
- d. Working prematurities right: NONE Location: _____
- e. Working prematurities left: NONE Location: _____
- f. Non-Working prematurities right: NONE Location: _____
- g. Non-Working prematurities left: NONE Location: _____

6. OTHER: _____

7. SUMMARY OF FINDINGS:

- a. Duration of problem: _____
- b. Previous treatment: _____
- c. Muscle involvement: _____
- d. Bone involvement: _____
- e. Ear involvement: _____
- f. Stress present: _____
- g. Other: _____
- h. Prognosis: _____

8. PROPOSED TREATMENT

- a. _____
- b. _____
- c. _____

Implant Prostheses

(Artificial Teeth Supported by Implants)

We have done our best to provide you with a well-fitted, functional, and esthetic implant prosthesis. We feel confident that you will adjust to these artificial teeth rapidly, and that you will have many years of satisfaction from them.

1. Your First Few Weeks: For several days, please chew more carefully than normal on these restorations. We will adjust the bite (occlusion) on future appointments until the teeth are well balanced. After you have adjusted to the prosthesis, it should function in a similar manner to natural teeth.

2. Cleaning the Implants and Prosthesis: The continuing success of the implants and prosthesis is up to you. Please do the following (items are checked):

a. Visit us for examination and cleaning of the teeth and prosthesis at least once every _____ months.

b. Clean the implant(s) and prosthesis daily, especially before bedtime using:

_____ Toothbrush

_____ Mechanical toothbrush

_____ Floss

_____ Bridge cleaner

_____ Water Pik

_____ Peridex

Please ask us about anything that is unclear relative to proper cleaning.

3. The Future: Your examination and professional cleaning appointments are very important to the long-term success of your implants and prosthesis. If your personal and professional cleanings and your examination appointments are accomplished routinely, your restorations should serve many years.

Please contact us if any of the conditions below occur:

- Awareness of looseness
- Peculiar taste
- Clicking or metallic snap while eating
- Breakage of a piece of the prosthesis
- Redness in the gum tissue around an implant
- Feeling of the bite being different
- Pain

I have read and understand the above information.

PATIENT'S NAME

SIGNATURE OF PATIENT, LEGAL GUARDIAN,
OR AUTHORIZED REPRESENTATIVE

DATE

Prótesis Sobre Implantes

(Dientes Artificiales Soportados por Implantes)

Hemos hecho todo lo posible para proporcionarle una prótesis de implante bien ajustada, funcional y estética. Estamos seguros de que se adaptará rápidamente a estos dientes artificiales y que tendrá muchos años de satisfacción con ellos.

1. **Sus Primeras Semanas:** Durante varios días, mastique con más cuidado de lo normal en estas restauraciones. Ajustaremos la mordida (oclusión) en futuras citas hasta que los dientes estén bien equilibrados. Una vez que se haya ajustado a la prótesis, debería funcionar de manera similar a los dientes naturales.
2. **Limpieza de los Implantes y Prótesis:** El éxito continuo de los implantes y prótesis depende de usted. Haga lo siguiente (los elementos están marcados):
 - a. Visítenos para revisión y limpieza de dientes y prótesis por lo menos una vez al mes.
 - b. Limpie los implantes y prótesis diariamente, especialmente antes de acostarse usando:
 - Cepillo de dientes
 - Cepillo de dientes mecánico
 - Seda floja
 - Limpiador de puentes
 - Water Pik
 - Peridex

Pregúntenos sobre cualquier cosa que no esté clara en relación con la limpieza adecuada.

3. **El Futuro:** Sus citas de examen y limpieza profesional son muy importantes para el éxito a largo plazo de sus implantes y prótesis. Si sus limpiezas personales y profesionales y sus citas de examen se realizan de forma rutinaria, sus restauraciones deberían servir muchos años.

Póngase en contacto con nosotros si se produce alguna de las siguientes condiciones:

- Conciencia de soltura
- Sabor peculiar
- Chasquidos o ruidos metálicos al comer
- Rotura de una pieza de la prótesis
- Enrojecimiento en el tejido de las encías alrededor de un implante
- Sensación de que la mordida es diferente
- Dolor

He leído y comprendo la información anterior.

NOMBRE DEL PACIENTE

FIRMA DEL PACIENTE, TUTOR LEGAL O
REPRESENTANTE AUTORIZADO

FECHA