LASER TREATMENT FOR PALATAL SNORING
CONSENT FORM

PATIENT INFORMATION

I. OVERVIEW

Dr. Brantley is trained in the practice of laser dentistry. You are seeking treatment for a significant snoring issue. If you have been diagnosed by your physician with Obstructive Sleep Apnea (OSA), you either 1) cannot tolerate or choose not to undergo Continuous Positive Airway Pressure (CPAP) therapy or Oral Appliance Therapy (OAT), or 2) you are choosing this treatment in conjunction with CPAP/OAT as an adjunct therapy. Over time, it is possible that snoring can develop into sleep apnea. Sleep apnea may also worsen as a result of other causes, including weight gain, age-related muscle weakening, hormonal imbalances, or pregnancy. Therefore, it is important to be screened annually. You acknowledge that if you have not previously been diagnosed with OSA, we have reviewed the risk factors for this condition with you, and, if appropriate, we have recommended that you be evaluated for OSA by an appropriate medical practitioner.

II. TREATMENT DESCRIPTION

Snoring may be caused by collapsing or obstructed nasal passages that lead to mouth breathing, mouth breathing from a relaxed jaw, the tongue dropping to the back of the throat and obstructing the airway, vibration of the soft palate and uvula, or a combination of these conditions. This treatment is intended to reduce palatal snoring by using a non-surgical (non-cutting) laser procedure to tighten loose tissue and maintain a more open airway during sleep and daytime hours.

This treatment does not cure snoring or sleep apnea. This treatment is only intended to treat palatal snoring and may not be effective if other conditions are also present. Due to variation in patient anatomy, re-treatment may be required. Treatment may need to be repeated each year if snoring comes back.

III. PROCEDURES AND PROTOCOL

1. Laser Treatment Consent Form Completed
2. Pre-Treatment Evaluation Performed
3. Topical Anesthetic Administered (optional)
4. Laser Treatment Performed
5. Re-Treatment Performed, as needed (if recommended by Dr. Brantley)

IV. RISKS

During the procedure, you may feel a warming or stinging in the tissue being treated. Gagging may occur during the procedure if the tongue needs to be depressed to access appropriate tissues and may be reduced or eliminated through the application of a topical anesthetic

spray. Post-operatively, you may feel a sensation similar to mild irritation for a day or two.

V. RIGHT TO REFUSE OR WITHDRAW CONSENT

You have the right to withdraw consent at any time before completion of the treatment. Premature withdrawal from treatment will reduce the maximum benefit of treatment and may result in no treatment benefit. It is important that you communicate if the treatment causes discomfort or pain or if you wish to discontinue treatment during procedure so that we can respond to your needs.

VI. ALTERNATE TREATMENT

Other accepted treatments for sleep-disordered breathing (such as snoring and sleep apnea) include behavior modifications, weight loss, hormonal therapy, myofunctional therapy/ frenectomy, surgical procedures, CPAP therapy, and oral appliance therapy. You have chosen laser therapy to treat your snoring and are aware that it may not be completely effective or may be less effective if not used in conjunction with other recommended treatments.

VII. UNUSUAL OCCURRENCES

As with any dental procedure, additional minor medical and dental risks that have not been described may occur. Good communication before, during, and after treatment is essential for the best treatment results. Please call or visit the office if you have any questions of problems regarding treatment.

VIII. CERTIFICATE OF CONSENT

I consent to photography, filming, recording, x-rays and/or digital imaging of the procedures before, during and after the treatment for the purpose of dental education and the advancement of dentistry. _____[**Initials**]
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions and any questions that I have asked have been answered to my satisfaction. I consent voluntarily and understand that I have the right to withdraw from the treatment at any time without in any way affecting my future dental or medical care.

_____ _____
Patient Signature Date

_____ _____
Signature of Guardian Date

_____ _____
Signature Physician/Designee Date