

Dr. Guy A. Spinner D.D.S.

16 Old Riverhead Rd.
Westhampton Beach, New York 11978
631-288-9000

Centric Occlusion Consent

_____ I have been advised that I have a neuromuscular jaw alignment condition that could be improved with comprehensive orthopedic and dental rehabilitative dentistry.

_____ I am declining that treatment and request that Dr. Spinner proceeds with his treatment to be fitted to my existing bite / jaw relation.

_____ I have also been advised that I may have temperature sensitivity, cracking of the teeth or restorations, and I will be responsible for all the costs associated with the replacement.

_____ I have also been advised that the temperature sensitivity may be permanent, and may worsen with time until such time as I decide to address the neuromuscular problem.

_____ I give this consent of my own free will. I read, speak, and understand English.

Initials

Signature of Patient

Date

Witness' Signature

Date