

INFORMED CONSENT FOR OXYGEN/OZONE THERAPY

I, _____, do voluntarily, knowingly, and willingly give my consent to the administration of dental oxygen/ozone treatments. I seek this treatment at my own request.

I understand that dental oxygen/ozone therapy involves the injection of a mixture of oxygen and ozone in the form of a gas with or without local anesthetic, into the skin, mucous membranes, muscles, joints, jawbones, and teeth of the head, neck and associated structures. Dental oxygen/ozone therapy is defined as the creation of a therapeutic oxygen rich environment, which induces a multi-factorial positive biochemical and physiologic change in the affected tissues. Dental oxygen/ozone therapy has the following dental relevant and useful properties: it kills bacteria, viruses, fungi and parasites. It is a circulatory stimulant, a wound-cleanser, an accelerant for wound healing, a hemostatic agent, and an immune activating agent. There may be other effects that at this time are unknown.

I understand that I should tell the doctor or staff if I have ever had an allergic reaction to any anesthetic, particularly dental anesthetics prior to any treatment involving injections with anesthetics.

There are potential side effects with all types of dental treatments. Dental oxygen/ozone therapy carries with it some risk of side effects, such as: pain and/or discomfort at the injection site, soreness and temporary bruising. There may be a red, inflamed, blister-type area at the injection site. This area usually heals in a 1-5 day time period. All types of medications have some risk of allergic reactions. An allergic reaction to the mixture of oxygen/ozone would be unusual, and usually restricted to the injection site. The most common patient comment is that there is a warm to burning sensation at the site of the injection. Some patients may experience flu-like symptoms for 2 to 3 days following treatment.

Patient/Legal Guardian

Date

Witness

Date

Limitations of Treatment using Dental concentrations of Oxygen/Ozone for the Treatment of the Head, Neck, Face, TMJ, Teeth, and Associated Structures:

I understand with any treatment, there is no guarantee that I will obtain satisfactory results. I may achieve no results, satisfactory results, or unsatisfactory results. If I am currently under the care of a physician or dentist for a known or unknown condition(s), it is my responsibility to inform all practitioners that are providing treatment(s) for my condition(s), of ALL other courses of treatment that I am receiving. Dr. Wall has advised me that it is in my best interest to integrate all therapeutic modalities that are available to treat my health condition(s).

I understand that Dr. Wall is not my primary care physician. I understand that it is in my best interest to have a primary care physician advise me in regard to any treatment(s) that I may choose to receive.

INFORMED CONSENT TO RECEIVE TREATMENT WITH DENTAL OXYGEN/OZONE

I hereby authorize treatment with dental oxygen/ozone and certify that I understand the nature of this treatment, including risks of possible complications and other choices that may be available. I have had any questions concerning this type of treatment answered. I consider myself to be as completely informed as possible and hereby consent to treatment using dental oxygen/ozone. I represent that I am seeking treatment in order to further my own health and for no other reason. I do not represent a third party. I am aware that I may withdraw this consent at any time.

Patient/Legal Guardian

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Rationale for treatment using dental oxygen/ozone

Dental oxygen/ozone has been shown to be an effective anti-bacterial, anti-fungal and anti-viral treatment agent. It increases circulation and oxygenation to the treatment area. It increases the immune response and creates an environment for the production of anti-oxidants.

Additional information and explanation for patients:

- Your disorder(s) may not respond to the treatment(s).
- You may experience pain, discomfort, soreness and bruising at and around the site of the injection.
- Transient small “bubble-like blisters” may occur at or around the site of the injection.
- All medications and treatments have some risk of allergic reaction(s). This is an unusual event and is usually restricted to the local area of the injection site.
- The most common side effect of dental oxygen/ozone treatment is a warm to burning or stinging sensation at the injection site.
- This treatment of your head, neck, face, TMJs, teeth, and associated structures, will on occasion produce flu-like symptoms, which last on average 2-5 days.
- Any new treatment technique may produce unanticipated effects. All known effects to date have been explained in this document. If you experience any reaction not described in this document, please contact Dr. Judson B. Wall and/or his staff. The office phone number is: 801-298-1812.
- You will be notified of any significant new findings, which are relevant to your treatment.

Witnessing and Signatures: I _____ have read the information and consent forms before signing. I understand that oxygen/ozone therapy in medicine has been used in the United States since 1885. This therapy has been grandfathered for medical use prior to the formation of the Food and Drug Administration. The FDA has not reviewed or approved of statements made in this informed consent. Results may vary. No claims are made regarding the application of any particular therapy using any particular products for any particular reason. I have been offered ample opportunity to ask questions and have received answers that are to my complete satisfaction.

Patient/Legal Guardian

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EXPERIMENTAL SUBJECT’S BILL OF RIGHTS

Any person who is requested to consent to participate as a subject in a research study involving a medical /dental experimental procedure, or who is requested to consent on behalf of another, has the right to:

- ___ Be informed of the nature and purpose of the experimental procedure.
- ___ Be given an explanation of the protocol to be followed in the medical/dental experimental procedure and information on the substance or device being evaluated.
- ___ Be given a description of any attendant discomforts and risks to be reasonably expected from the experimental procedure, when applicable.
- ___ Be given a disclosure of any appropriate alternative procedures, substances, drugs or devices that might be advantageous to the subject, and their relative risks and benefits, if known.
- ___ Be given an explanation of any benefits to the subject to be reasonably expected from the experimental procedure, if applicable.
- ___ Be informed of the courses of medical/dental treatment, if any, available to the subject after the experimental trial if complications should occur.
- ___ Be given the opportunity to ask any questions concerning the experimental trial or other associated procedures.
- ___ Be instructed that consent to participate in the medical/dental experimental procedure may be withdrawn at any time, and that the subject may discontinue participating in the medical/dental experiment without prejudice.
- ___ Be given a copy of the signed and dated written consent form when one is required.
- ___ Be given the opportunity to decide to consent or not to consent to a medical/dental experimental procedure without the intervention of any element of force, fraud, coercion, or undue influence on the subject’s decision.

Patient/Legal Guardian

Date

Witness

Date