



Informed Consent Form for NightLase™ Laser Snoring and Sleep Apnea Reduction

Dr. Chris Theodorou DMD

Information:

Dr. Chris Theodorou is currently practicing laser dentistry. You have a significant snoring issue and if you have been diagnosed with Obstructive Sleep Apnea you either cannot tolerate or chose not to tolerate CPAP or a Mandibular Advancement Device. If you do not have a previous diagnosis we have reviewed with you the medical disorders that may be related such as high blood pressure, weight gain, hormone imbalances, stroke and coronary artery disease to name a few. If appropriate we have recommended that you seek medical care for screening for OSA (Obstructive Sleep Apnea) with your medical practitioner.

Purpose:

This treatment is an alternative procedure for patients who cannot tolerate CPAP and or Mandibular Advancement Devices. Nightlase has been found to be a therapy that is beneficial in reducing snoring and OSA or its side effects by opening the airway.

Type of Dental Intervention:

Erbium: Yag Laser non ablative (non cutting) treatment of the soft palate and surrounding area.

Procedures and Protocol:

1. Treatment Consent
2. Photos / Video Consent
3. Pre-op Photos
4. Fill out Pre treatment evaluation
5. Laser treatment approximately 60 minutes
6. 3 repetitions of Laser treatment -21 days apart
7. Post operative photos

A. Unfamiliar Procedure:

The intra-oral use of Erbium: Yag Laser.

Post operatively; you may feel a sensation similar to a mild throat irritation for a day or two.

Duration:

Treatment will consist of three (3) 60 minute sessions three (3) weeks apart.

Risks:

There are no risks other than that you may not perceive an improvement in your symptoms.

Possible Benefits:

- Improved Sleep quality
- Reduced fatigue
- Weight loss
- Happier spouse / family

Length of Treatment:

The Nightlase treatment is strictly a therapy to help maintain a more open airway during sleep and daytime hours. It does not cure snoring or sleep apnea. Due to patient variation the treatment may last from 6-12 months requiring some retreatment. Over time simple snoring may develop into sleep apnea. Sleep apnea may also become worse. Therefore, it is important to be screened yearly. If unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.

Individuals who have been diagnosed as having sleep apnea may notice that after Nightlase treatment they feel more refreshed and alert during the day. This is only subjective evidence of improvement of OSA and may be misleading. The only way to accurately measure whether the Nightlase treatment has assisted in keeping the oxygen levels sufficiently high to prevent abnormal heart rhythms and other problems is to be retested with a sleep recorder or polysomnograph.

Confidentiality:

All data will be kept confidential, only the results will be tabulated for research according to standard protocols.

Right to Refuse or Withdraw:

You have the right to withdraw before completion of the treatment.

Alternative Treatments:

Other accepted treatments for sleep-disordered breathing (such as snoring or sleep apnea) include behavior modification, weight loss, surgical procedures and CPAP appliances or oral appliances. You have chosen Nightlase therapy to treat your particular problem and are aware that it may not be completely effective for you.

Unusual Occurrences:

As with any form of medical or dental treatment, unusual occurrences can and do happen. Mouth sores, muscle spasms and sore jaw muscles are all possible occurrences. Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it 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 medical care. I consent to the taking of photographs, video and any necessary x-rays before, during and after treatment, and their use in scientific papers, demonstrations or discussions of the procedure in social media, print and online.

Print Name of Patient _____

Signature of Patient _____

Date _____
Day/ Month/year

Print Name of Witness _____

Signature of Witness _____

Date _____
Day/month/year

I have accurately read or witnessed the accurate reading of the consent form to the potential patient, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print Name of treating Doctor _____

Signature of treating doctor _____

Date _____
Day/month/year

A copy of this Informed Consent Form has been provided to participant ____ (initialed by the Doctor/assistant)

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**PRE-NIGHTLASE TREATMENT EVALUATION
FOR SLEEP PARTNER/FAMILY MEMBER**

Patient: _____ Date: _____

Sleep Partner/Family Member: _____

Noise Level: 1 2 3 4 5 6 7 8 9 10

Noticed Weight Gain: 1 2 3 4 5 6 7 8 9 10

Disturbance to your Sleep: 1 2 3 4 5 6 7 8 9 10

Personality Changes: Grumpy Forgetful Other _____

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**PRE-NIGHTLASE TREATMENT EVALUATION
FOR PATIENT**

Patient: _____ Date: _____

Reasons For Seeking Treatment: _____

Quality of Sleep: 1 2 3 4 5 6 7 8 9 10

Disturbance to Spouse or Family: 1 2 3 4 5 6 7 8 9 10

Weight Gain: 1 2 3 4 5 6 7 8 9 10

Health Issues: Sleep Apnea Blood Pressure Cholesterol

Medications: _____

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Adult Model Release

In consideration of my engagement as a model, upon the terms herewith stated, I hereby give to Chris B. Theodorou DMD his heirs, legal representatives and assigns, those for whom Chris B. Theodorou DMD is acting, and those acting with his authority and permission:

a) the unrestricted right and permission to copyright and use, re-use, publish and republish photographic portraits, videos or pictures of me or in which I may be included intact or in part, composite or distorted in character or form, without restriction as to changes or transformations in conjunction with my own or a fictitious name, or reproduction hereof in color or otherwise, made through any and all media now or hereafter known for illustration, art, promotion, advertising, trade, or any other purpose whatsoever.

b) I also permit the use of any printed material in connection therewith.

c) I hereby relinquish any right that I may have to examine or approve the completed product or products or the advertising copy or printed matter that may be used in conjunction therewith or the use to which it may be applied.

d) I hereby release, discharge and agree to save harmless [photographer], his/her heirs, legal representatives or assigns, and all person functioning under his/her permission or authority, or those for whom he/she is functioning, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

e) I hereby affirm that I am over the age of majority and have the right to contract in my own name. I have read the above authorization, release and agreement, prior to its execution; I fully understand the contents thereof. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Name: _____

Date: _____

Signature: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Witness: _____