RESTORATIVE ORAL HEALTH

BEST-BITE

Patient Release Form for the Best-Bite™ Discluder

I understand that my Best-Bite™ Discluder is used to assist in the diagnosis of muscle spasm pain due to occlusal interference and as a temporary pain reliever.

I agree to always use my retention leash around my neck before placing the Best-Bite™ Discluder on my teeth.

I also agree that if I experience ANY negative reaction such as sensitivity, rash or pain from using the Best-Bite™ Discluder that I will immediately stop using it and seek professional help from the doctor who dispensed it.

I understand that if I use the Best-Bite™ Discluder other than as instructed, it is possible that my teeth could shift and worsen my bite.

I agree to store the Best-Bite™ Discluder in its box when it is not in use and keep it away from children and pets.

I agree to hold Whip Mix Corporation and its employees and the doctor who dispensed the Best-Bite™ Discluder to me harmless from any incidents that may arise out of my improper use of the Best-Bite™ Discluder or my failure to follow the written instructions.

I understand that the Best-Bite™ Discluder is a temporary device to let me see and feel how I would feel when my teeth do not force my jaw out of its socket.

I understand that the Best-Bite™ Discluder will not cure any condition. It is only to assist the doctor in determining if my pain is due to a conflict between my teeth and jaw joints and to provide temporary pain relief during the course of a professional treatment program.

I understand that the effects of the Best-Bite™ Discluder are temporary.

I understand that if using the Best-Bite™ Discluder relieves my pain it is almost certain that my bite is the source of my pain and conversely, if the Best-Bite™ Discluder does not relieve my pain it is most likely that my bite is not the source of my pain.

My signature on this release signifies that I have read all the conditions and that they have been explained to me. I have had the opportunity to ask my questions and agree to follow the written instructions.

Name (Patient):_____**Date:**_____

Name (Witness):_____**Date:**_____