

ICMJE DISCLOSURE FORM

Date: 2/25/22 _____
 Your Name: Sowmya Ananthan _____
 Manuscript Title: Use of injection techniques in orofacial pain emergencies _____
 Manuscript number (if known):_ N/A _____

In the interest of transparency, we ask you to disclose all relationships/activities/interests listed below that are related to the content of your manuscript. "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the manuscript. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

The following questions apply to the author's relationships/activities/interests as they relate to the current manuscript only.

The author's relationships/activities/interests should be defined broadly. For example, if your manuscript pertains to the epidemiology of hypertension, you should declare all relationships with manufacturers of antihypertensive medication, even if that medication is not mentioned in the manuscript.

In item #1 below, report all support for the work reported in this manuscript without time limit. For all other items, the time frame for disclosure is the past 36 months.

		Name all entities with whom you have this relationship or indicate none (add rows as needed)	Specifications/Comments (e.g., if payments were made to you or to your institution)
Time frame: Since the initial planning of the work			
1	All support for the present manuscript (e.g., funding, provision of study materials, medical writing, article processing charges, etc.) No time limit for this item.	<input checked="" type="checkbox"/> None	
Time frame: past 36 months			
2	Grants or contracts from any entity (if not indicated in item #1 above).	<input checked="" type="checkbox"/> None	
3	Royalties or licenses	<input checked="" type="checkbox"/> None	
4	Consulting fees	<input checked="" type="checkbox"/> None	

5	Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	<input checked="" type="checkbox"/> None	
6	Payment for expert testimony	<input checked="" type="checkbox"/> None	
7	Support for attending meetings and/or travel	<input checked="" type="checkbox"/> None	
8	Patents planned, issued or pending	<input checked="" type="checkbox"/> None	
9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> None	
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input checked="" type="checkbox"/> None	
11	Stock or stock options	<input checked="" type="checkbox"/> None	
12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None	
13	Other financial or non-financial interests	<input checked="" type="checkbox"/> None	

Please summarize the above conflict of interest in the following box:

Please place an "X" next to the following statement to indicate your agreement:

I certify that I have answered every question and have not altered the wording of any of the questions on this form

ICMJE DISCLOSURE FORM

Date: 2/27/22
 Your Name: Samuel Quek
 Manuscript Title: Use of Injection Techniques in Orofacial Pain Emergencies
 Manuscript number (if known): _____

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ICMJE DISCLOSURE FORM

Date: 8/3/2022

Your Name: SITA MAHALAKSHMI BADDIREDDY

Manuscript Title: INJECTION TECHNIQUES IN OROFACIAL PAIN URGENT CARE: A NARRATIVE REVIEW

Manuscript Number (if known): Click or tap here to enter text.

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4	Consulting fees	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 365 1469 504"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
5	Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 577 1469 683"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
6	Payment for expert testimony	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 902 1469 1008"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
7	Support for attending meetings and/or travel	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 1108 1469 1214"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
8	Patents planned, issued or pending	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 1314 1469 1420"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 1520 1469 1626"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input checked="" type="checkbox"/> None <table border="1" data-bbox="389 1704 1469 1809"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>							

		Name all entities with whom you have this relationship or indicate none (add rows as needed)	Specifications/Comments (e.g., if payments were made to you or to your institution)
11	Stock or stock options	<input checked="" type="checkbox"/> None	
12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None	
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Sita Mahalakshmi Baddireddy

ICMJE DISCLOSURE FORM

Date: February 25th, 2021

Your Name: Julyana Gomes Zagury

Manuscript Title: Use of Injection Techniques in Orofacial Pain Emergencies

Manuscript number (if known): _____

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<p>I have no conflict of interest to declare</p>
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