BRYAN T. MOORE, DDS, PA
— General Dentist Providing Oral Surgery Services —
214.529.5218 (cell) bryan@bryanmooredds.com www.bryanmooredds.com

PRE-OPERATIVE INSTRUCTIONS FOR DENTAL SURGERY

**** VERY IMPORTANT INFORMATION – PLEASE READ CAREFULLY ****

**** COMPLETE ATTACHED "MEDICAL HISTORY UPDATE FORM" ****
& RETURN IT TO YOUR DENTIST PRIOR TO SURGERY

1. If you have any concerns or questions about the surgery, please contact Dr. Moore at 214.529.5218 or by email at bryan@bryanmooredds.com.
2. I will be reviewing your medical history with you immediately prior to the surgery. Please be sure you are familiar with that information—especially with the name(s) and dosage(s) of any medications you are taking. If you feel your history is relatively complicated, we will need to decide if a consultation with your physician is necessary before the procedure is performed.
3. Patients who are minors (under 18 years of age) must have a legal guardian present to both fill out the "Medical History Update Form" and to sign the "Disclosure and Consent Form."
4. It is important to avoid smoking for at least one week before the surgery and one week following the surgery.
5. Keep in mind that it is best to allow for some flexibility around your appointment time on the day of your surgery. It is best not to "squeeze in" an appointment for surgery on an already busy day.

If you are having IV (intravenous) conscious sedation:

1. To reduce the chances of nausea, do not eat or drink anything (including water) for *at least six hours prior to your appointment*.
   a. If your surgery is in the morning, do not eat or drink anything between bedtime and your scheduled appointment.
   b. If your surgery is in the afternoon, a light breakfast before 7:00 a.m. is encouraged.
   c. Unless specified by your dentist, all medicines taken on a routine basis should be continued without interruption. Please swallow with a minimal amount of water.
2. **A responsible adult, over 18 years of age, should accompany you to the office and should *remain in the office during the entire procedure*. Following the sedation, this responsible adult should be physically capable of assisting and accompanying you home and should remain with you for the next 24 hours.**
3. If receiving intravenous sedation, you should wear clothing that is not restricting to the neck or arms. You should wear loose-fitting tops on which the sleeves can be rolled up to the shoulder. Also, please be sure to wear shoes that are securely fastened; no flip-flops or loose-fitting sandals, please.
4. Following the sedation, you should refrain from driving an automobile or from engaging in any activity that requires alertness for the next 24 hours.
5. There are important differences between general anesthesia (being completely asleep) and IV conscious sedation. If you have any questions about the IV conscious sedation process, please feel free to contact Dr. Moore at 214.529.5218 prior to the procedure.

NOTE: Additional pre-operative information can be found at *www.bryanmooredds.com*. I recommend you preview the "Disclosure and Consent Form" on the website, or you can request a copy from your dentist.

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MEDICAL HISTORY UPDATE FORM

Name_____ Date_____
Last First Middle

Ht_____ Wt_____ Date of Birth_____ Dentist's Name_____

If you are completing this form for another person, what is your relationship to that person?_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition?_____
5. The name and address of your physician is:

   _____

   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Are you taking any medicine(s), including non-prescription medicine(s)? ..... Yes No
   If so, what medicine(s) are you taking?_____

   _____
8. Have you ever taken Aredia, Zometa, Fosamax, Actonel, or Boniva? ..... Yes No
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease ..... Yes No
   b. Cardiovascular disease, angina, heart attack, heart trouble, stroke ..... Yes No
   c. Osteoporosis ..... Yes No
   d. Cancer requiring IV chemotherapy ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Diabetes ..... Yes No
   h. Hepatitis, jaundice, or liver disease ..... Yes No
   i. AIDS or HIV infection ..... Yes No
   j. Thyroid problems ..... Yes No
   k. Respiratory problems, bronchitis, etc. Yes No
   l. Sleep apnea or snoring during sleep ..... Yes No
   m. Stomach ulcer or hyperacidity ..... Yes No
   n. Kidney trouble ..... Yes No
   o. High or low blood pressure ..... Yes No
   p. Sexually transmitted disease ..... Yes No
   q. Epilepsy/other neurological disease? ..... Yes No
   r. Problems with the spleen ..... Yes No
10. Have you had abnormal bleeding? ..... Yes No
    Or required a blood transfusion? ..... Yes No
11. Do you have any blood disorder such as anemia? ..... Yes No
12. Have you been treated for a tumor? ..... Yes No
13. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, sleeping pills .... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Other_____

Women

14. Are you pregnant? ..... Yes No
15. Do you have any menstrual problems? ..... Yes No
16. Are you nursing? ..... Yes No
17. Are you taking birth control pills? ..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

_____
Signature of Dr. Moore

_____
Signature of Patient (or Patient's Guardian)

**** RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY ****

BRYAN T. MOORE, DDS, PA

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PATIENT TREATMENT RECORD

Patient Name_____ **Age**_____ **DOB**___/___/___ **DOS**___/___/___

Address_____ **City/ST**_____ **Zip**_____

Email_____ **Phone**_____

Escort/Driver_____ **Phone**_____

Pharmacy_____ **Phone**_____

Acknowledgment: Receipt of Notice of Privacy Practices (Form 7 of 7) allows for contact by: ☐ Phone ☐ Email ☐ Mail

FOR DENTIST'S USE ONLY BELOW

Medical History Findings/ROS_____

Current Medications_____

Allergies_____

Pre-op Meds (last 24 hrs.)_____

Patient Surgical/Anesthesia History_____

Family Surgical/Anesthesia History_____

Smoker: Y / N **Vape/Smokeless:** Y / N **EtOH/Rec. drug abuse:** Y / N **Sleep Apnea:** Y / N **Pregnancy:** Y / N / NA

Procedure Planned_____

Diagnostic Criteria: Perio_____ Crowding/Ortho_____ Prev. Pain/Swelling_____ Non-Restorable_____ Cyst_____ Pt. Election_____

Pre-Operative Imaging: ☐ CBCT ☐ Pano ☐ PA ☐ Other_____ **Imaging Date**_____/_____/_____

Dental Office_____ **Total Fee**_____

Surgical Fee_____ **Implant Fee**_____ **Materials Fee**_____ **Assistant Fee**_____

Pre-Operative Sedation/Anesthesia Checklist

☐ Medical history reviewed
☐ Known allergies reviewed
☐ Patient surgical/anesthesia history reviewed
☐ Family surgical/anesthesia history reviewed
☐ Patient medications reviewed/modified
☐ Pre-operative instructions given (*written & verbal*)
☐ Post-operative instructions given (*written & verbal*)
☐ Pre-procedure treatment review completed (*confirmation of correct patient & procedure*)
☐ Reversal/resuscitation agents are present, out, and unexpired
☐ Pediatric/high-risk pre-operative considerations addressed
☐ Medical consult (*as needed*)
☐ Consent(s) signed: ___Dental/oral surgery ___Supplemental ___Implant ___Notice of Privacy Practice Acknowledgment
☐ Documentation of physical examination *(including ASA classification, NPO status, and pre-operative vitals—height, weight, BP, HR, RR)*
☐ Documentation of anesthesia-specific physical examination *(including Mallampati score and/or Brodsky score and auscultation)*
☐ Pre-procedure equipment readiness check completed (*monitors on/operating, sufficient O2 supply, AED/BVM/OPA/LMA present*)
☐ Pre-procedure emergency readiness check completed *(emergency protocols present and emergency roles reviewed)*

Explanation of any omissions_____

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PATIENT TREATMENT AND SEDATION/ANESTHESIA RECORD

Patient Name_____ **Age**_____ **DOB**____/____/_____ **DOS**____/____/_____

Dental Office_____ **Individuals Present**_____

Physical Exam: Ht_____ Wt_____ BMI_____ Auscultation Findings: *WNL; Rales; Wheezes; Other*_____

Mallampati/Brodsky Score_____ ASA Classification_____

Pre-operative Vitals: EKG_____ SpO2_____ BP_____ HR_____ RR_____ N.P.O. > _____ hrs.

Prescriptions Given:

*Control #*_____

*Norco 7.5/325mg x*_____

*Tylenol #3 x*_____

*Amox 500mg x*_____

*Cleocin 150mg x*_____

*Zofran ODT 8mg x*_____

*Peridex (1 pint) x*_____

*Other*_____

☐ *Opioid Rx Alt. Option/ Safety Discussion*

Start Time :	→ 0	05	10	15	20	25	30	35	40	45	50	55	60	Admin/Wasted
Midazolam/cc	5 mg/cc													/
Diazepam/cc	5 mg/cc													/
Fentanyl/cc	50 mcg/cc													/
Dexamethasone	4 mg/cc													/
														/
Oxygen (L/min)														
N20 (L/min)														
Fluids:														
2% Lidocaine Carps.	1:100k													
0.5% Marcaine Carps.	1:200k													

Time-oriented vitals strips:

Treatment/Clinical Notes_____

☐ **Continually evaluated color of mucosa, skin, or blood** ☐ **Ligated airway protection used**

☐ **Continually evaluated ventilation:** *precordial steth.; end-tidal CO2; verbal comm. w/ pt.*

☐ **Sutures:** *silk; gut; vicryl;*_____

☐ **Post-Operative/Anesth. Instructions O&W** ☐ **D/C Criteria Met: Aldrete Score**_____ **D/C Time** :

Doctor's Signature_____ **Date**_____

For Office Use Only:

1st Post-Op Call _____

Record Posted _____

Drug Log Entry _____

1-wk. Post-Op Call _____

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DISCLOSURE AND CONSENT – DENTAL AND ORAL SURGERY

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request Bryan T. Moore, DDS, PA and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, periodontally-involved, and/or impacted teeth_____

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by: ____ Nitrous Oxide ____ IV Sedation ____ Oral Sedation

Surgical Extraction of Teeth_____

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Moore in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) understand Dr. Moore is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Moore from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Moore is a general dentist, and I(we) give Dr. Moore and such associates permission to video or photograph procedure(s) for diagnostic and/or teaching purposes only.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, cardiac arrest, brain injury, and even death. I(we) also realize that the following risks and hazards may occur in connection with this particular procedure:

_____ 1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums.

_____ 2. Damage to adjacent teeth and/or dental restorations.

_____ 3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws.

_____ 4. Opening of the sinus requiring additional treatment.

_____ 5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks.

_____ 6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications.

_____ 7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent.

_____ 8. Other_____

I(we) understand that IV conscious sedation (“twilight sleep”) and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV conscious sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures. I(we) realize the IV conscious sedation and/or other forms of supplemental anesthesia may have to be changed possibly without explanation to me(us). I(we) understand this is not general anesthesia (being completely asleep), and that it is unlikely, but I may have unpleasant memories of the procedure.

I(we) understand that certain complications may result from the use of any IV sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of IV sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal chords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents

DATE:_____ TIME:_____

_____	/_____
Signature of Patient or Other Legally-responsible Person	/ Patient's Name (Please Print)

WITNESS:_____ DATE:_____

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SUPPLEMENTAL DISCLOSURE & CONSENT

INFORMATION FOR PATIENTS REGARDING POSSIBLE CHANGES IN SENSATIONS OF THE LIP, CHIN, OR TONGUE FOLLOWING DENTAL SURGERY.

Dental surgery, like any other surgery, has certain inherent risks and limitations that may occur despite the experience and skill of the doctor. Following your surgery, it is possible that you may experience either temporary or permanent changes in the sensation or feelings of your lip, chin, or tongue. Permanent changes in sensation of the affected areas are extremely rare.

WHAT CAN CAUSE IT?
Because the nerves that supply these regions are close to the area where the surgery is performed, the nerves may not function normally for a while afterwards. These nerves affect sensation only and not movement.

The most common cause of this type of injury is from the pressure that can occur during either the removal of a tooth root or by the placement of an implant in the lower jaw. Occasionally, hooks or curves on the root may tear some of the nerve fibers. Another possible cause of injury is during the administration of the local anesthesia (numbing medicine). X-rays are helpful but cannot tell us the exact location of the important structures. When the nerve is especially close to the site of the surgery, it could be nicked or cut. Additionally, the incidence and severity of nerve injuries increases with age. This is particularly true for lower wisdom teeth. Further, sometimes sensation is affected without knowing exactly what caused it.

HOW LONG WILL IT LAST?
The likelihood that a change in sensation will occur and how long it will last can depend on many factors, including position of the tooth, the nerve, or the difficulty of the procedure. The duration of the condition is unpredictable and different in each case. It may last a few days, weeks, or months, and in very rare instances, may be permanent. In the majority of cases, the sensory loss gradually returns to normal although you may not be aware of any immediate improvement. Nerve tissue is the slowest tissue in the body to heal, and it can be weeks or months before you notice significant improvements. Nonetheless, it is important for you to stay in touch with us, so we may advise you of your specific circumstances.

HOW CAN I TELL IF I AM GETTING BETTER?
During nerve recovery, you may notice changes such as tingling, as if a local anesthetic is wearing off. Other sensations may also be present. Do not be alarmed; this is often a positive sign. It is important for you to help us in recording any changes in your symptoms so that we may better answer your questions and advise you as to your prognosis.

WHAT IF IT DOESN'T GET BETTER? CAN ANYTHING BE DONE?
If there has been absolutely no improvement in six weeks, then depending on your case, microsurgical repair could be considered. We can further council you on this possibility, and you will be referred to a specialist who is experienced and knowledgeable in this area.

IN SUMMARY
Remember, in the overwhelming number of instances of altered sensation, all or most of the normal sensation will return. If residual symptoms do remain, the risks involved with surgical repair may not be warranted, in that spontaneous, post-operative recovery may take up to two years to occur. By keeping in close contact with us, we are better able to advise you throughout your recovery process to insure optimum results.

Patient's Name (printed)	Signature of Patient (or Patient's Guardian)
Signature of Dr. Moore	Date Signed

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POST-OPERATIVE INSTRUCTIONS FOLLOWING DENTAL SURGERY

THINGS TO EXPECT:

Bleeding: Bleeding or "oozing" for the first 12 to 24 hours.

Swelling: This is normal following a surgical procedure in the mouth. It should reach its maximum in two-to-three days and should begin to diminish by the fifth post-operative day.

Discomfort: The most discomfort that you may experience may occur for a few hours after the sensation returns to your mouth. It may gradually increase again for 2-3 days, then begin to diminish over the next few days.

THINGS TO DO IMMEDIATELY FOLLOWING SURGERY:

Bleeding: Place gauze over extraction sites and maintain pressure by biting for at least one hour. Repeat as needed. Keep head elevated, and rest. Do not suck or spit excessively. (Also, please refrain from blowing into musical instruments.)
NOTE: Some "oozing" and discoloration of saliva is normal. If bleeding persists, replace the gauze with a clean folded gauze placed over the extraction site, and maintain the pressure until the bleeding stops.

Swelling: Place ice or cold compresses on the region of surgery for ten minutes every half-hour for the first eight to 12 hours.
NOTE: Ice bags or cold compresses should be used only on the day of surgery.

Smoking: Avoid smoking during the healing period.

Discomfort: Take medications as directed for PAIN. Mild-to-moderate pain can be relieved by non-prescription Advil, Aleve, or Orudis. For more severe pain, take the prescription pain medication as directed. Remember that these medications can take up to 30 minutes to one hour to take effect. If you are using any of these medications for the first time, exercise caution with the initial doses (start with ½ a pill).

Diet: A nutritious liquid or soft diet will be necessary for the first weeks after surgery. Healing will occur in weekly increments; therefore, it is best to gradually (in weekly increments) return the diet and/or other mouth/oral activities back to normal.

Physical Activity: For the first 24 to 48 hours, one should REST. Patients who have sedation should refrain from driving an automobile or from engaging in any task that requires alertness for the next 24 hours.

THE DAYS AFTER SURGERY:

1. Brush teeth carefully.
2. Beginning 24 hours after the surgery, rinse mouth with the prescription mouth rinse. Continue rinsing three-to-five times per day for seven days, then begin irrigating per dentist's instructions (see #7 below).
3. If *ANTIBIOTICS* are prescribed, be *SURE* to take *ALL* that have been prescribed, *AS DIRECTED*.
4. Use *WARM, MOIST HEAT* on face for swelling, if any. Continue until the swelling subsides. A warm, wet washcloth or heating pad will suffice.
5. If *SUTURES* were used, they will dissolve on their own.
6. *DRY SOCKET* is a delayed healing response, which may occur during the second-to-fourth post-operative day. It is associated with a throbbing pain on the side of the face, which may seem to be directed up toward the ear. In mild cases, simply increasing the pain medication can control the symptoms. If this is unsuccessful, please call Dr. Moore.
7. **RETURN TO YOUR DENTIST'S OFFICE** five-to-seven days after the surgery for irrigation instructions.
8. Additional post-operative information can be found at *www.bryanmooredds.com.*

CONTACT THE DOCTOR IF:

1. Bleeding is excessive and cannot be controlled.
2. Discomfort is poorly controlled.
3. Swelling is excessive, spreading, or continuing to enlarge after 60 hours.
4. Allergic reactions to medications occur, which are causing a generalized rash or excessive itching.

CONTACT EMERGENCY MEDICAL SERVICES ("EMS") OR CALL "911" IF:

Patient loses or has lost consciousness.

***** BE SURE TO CHECK THE WEBSITE FOR ADDITIONAL INFORMATION *****
— www.bryanmooredds.com —

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Top 10 Do's & Don'ts

DO's

1. Do change the gauze every 30 minutes until bleeding slows. Gauze should only be needed for the first few hours.
2. Do eat ice cream after surgery for the remainder of the day (Frosty's from Wendy's are recommended and are Dr. Moore's favorite.) ☺
3. Do eat liquid/mushy food for 14 days (i.e., soups, smoothies, mashed potatoes, pudding, macaroni & cheese, yogurt, Ensure, Jell-O, milkshakes, etc.).
4. Do only eat foods that you can swallow without chewing.
5. Do use a spoon for eating.
6. Do expect your mouth to be numb for 6-12 hours after surgery.
7. Do eat 15 minutes prior to taking pain medicine.
8. Do expect pain and swelling to peak on the 2nd and 3rd days.
9. Do return to the dental office in five-to-seven days for post-op appointment.
10. **Do call Dr. Moore if things are not improving week-by-week (214.529.5218).**

DON'Ts

1. Don't use the gauze for more than a few hours after the surgery.
2. Don't sleep, eat, or drink with gauze in your mouth.
3. Don't leave the patient alone for the first 24 hours.
4. Don't chew while eating for 14 days.
5. Don't smoke, dip, or drink alcohol for seven full days.
6. Don't use a straw for eating or drinking for seven days.
7. Don't exercise hard for seven full days.
8. Don't blow your nose, or hold in a sneeze for seven days.
9. Don't miss or skip your post-op visit five-to-seven days after surgery.
10. **Don't hesitate to call Dr. Moore if things aren't improving week-by-week (214.529.5218)**

BRYAN T. MOORE, DDS, PA
— General Dentist Providing Oral Surgery Services —

_____ (ofc) 214.529.5218 (cell) bryan@bryanmooredds.com www.bryanmooredds.com

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Bryan T. Moore, DDS, PA's Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print)_____

_____ _____
Signature of Patient Date Signed

****

I am a parent or legal guardian of _____ (patient's name). I have received a copy of Bryan T. Moore, DDS, PA's Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

_____ _____
Signature of Parent or Legal Guardian Date Signed

I authorize the doctor and his staff to contact me by ____phone ____email ____mail *(check all that apply)*

****

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on _____ (date)

☐ In Person ☐ Email ☐ Mail ☐ Other_____

Reason patient or patient's parent/legal guardian did not sign this form:

☐ Did not want to sign
☐ Did not respond after more than one attempt
☐ Other_____

_____ _____
Staff Member's Name (please print) Title

_____ _____
Signature of Staff Member Date Signed

BRYAN ▪ T ▪ MOORE
DDS ▪ PA

Physician Report and
Medical Consultation for Dental Surgery

Dear _____, M.D.: Date of Request:_____

Our mutual patient, _____, is planning on having dental surgery with local anesthesia and possibly IV conscious sedation. **Potential intra-operative medications include:** Valium, Versed, Fentanyl, Phenergan, Dexamethasone, Lidocaine with Epinephrine, Marcaine with Epinephrine, and Nitrous Oxide. **Potential post-operative medications include:** Lortab, Penicillin, Phenergan, Peridex, Cleocin, Ibuprofen, and Tylenol. Please evaluate his/her medical condition and report back to us, *in writing*, with the following information:

_____

_____

TO BE COMPLETED BY THE PHYSICIAN

Name of Reporting Physician:_____ **Date of Report:**_____

Address of Reporting Physician: _____

Phone No. of Reporting Physician: (_____) _____

1. **List of all current medications:**_____

   _____

   _____

2. **List of known medical conditions:**_____

   _____

   _____

3. **List of known drug allergies:**_____

4. **Are there any special precautions or contraindications to the proposed treatment?** *(Please be as specific as possible.)*

   _____

   _____

5. **Do you feel this patient can be safely treated in the dental office setting? Yes or No** *(please circle one)*

_____
Signature of Physician

As the reporting physician, please either use this form or send your own information. For your convenience, you may fax your response to 972/231-9212. If you have any questions regarding the above, please call Dr. Bryan Moore at 214/529-5218. Thank you.

Sincerely,

Bryan T. Moore, D.D.S., P.A., working with _____, D.D.S.

▪ PHONE: 214.529.5218 ▪ FAX: 972.231.9212 ▪
▪ email — bryan@bryanmooredds.com ▪ web — www.bryanmooredds.com ▪

GENERAL DENTIST PROVIDING ORAL SURGERY SERVICES

BRYAN T. MOORE, DDS, PA
Dental Implant Consent Form

Patient Name_____ Dental Office_____

Date_____

I have been fully informed of the nature of implants and implant surgery, therapeutic risks, and treatment alternatives to dental implants, and I hereby consent to their surgical placement in my jaws (mouth). I agree to maintain these implants as prescribed by my dentist.

Nature of Procedure Implant Locations_____

The initial surgical phase consists of the surgical reflection of the gum tissue followed by precision drilling of holes into the underlying jawbone which depth and width are somewhat smaller than the roots of your natural teeth. These holes are immediately filled with metal cylindrical posts (implants), which are designed to remain in the jawbone indefinitely. In some situations, where inadequate bone is present, a regenerative procedure might be utilized in which a freeze-dried bone graft is placed and the site is then covered with a regenerative membrane. All surgery is performed under local anesthesia and may be supplemented with sedative drugs or IV Conscious Sedation (if requested by the patient or if deemed necessary).

During the first two (2) weeks following the initial surgery, no dentures or partial dentures should be worn over the surgical sites without consent of the surgeon.

The second surgical procedure usually occurs three-to-eight months after the initial surgery. At this time the implant is evaluated for proper healing and a post is placed into the implant, which extends through the gum tissue into your mouth. Additionally, a minor surgical correction of tissue may later be necessary to modify any tissue overgrowths or discrepancies.

In the final prosthetic phase, a metal sleeve is threaded into the previously surgically imbedded implant, which is then attached (anchored) to the overlying denture, crown, or bridge. The fee for the prosthetic phase is separate and not part of the surgical fee.

Alternative Treatments to Implants

1. If no treatment is elected to replace existing dentures or missing teeth, the non-treatment risk includes maintenance of the existing full or partial denture with relines or remakes every three-to-five years for shifting of teeth, or as otherwise may be necessary due to the slow but progressive resorption (dissolution) of the underlying (supporting) jawbone.
2. Construction of new full or partial dentures or bridges, which may provide better fit and function than your present situation.
3. Surgical treatment to provide a better base or foundation for a new denture. Associated risk and benefits of alternative surgical procedures may be explained in greater detail by consulting an oral surgeon.

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Initial Here

GENERAL DENTIST PROVIDING ORAL SURGERY SERVICES
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Risks

1. Surgical risks include, but are not limited to: post-surgical infection; bleeding; swelling; pain; facial discoloration; sinus or nasal perforation during surgery; TMJ (jaw joint) injuries or spasms; bone fractures; slow healing; and, transient, but on occasion, permanent numbness of the lip, chin, and tongue.

2. Prosthetic implant risks include, but are not limited to: unsuccessful union of the implant to the jawbone and/or stress metal fractures of the implant. After one (1) year of stable implant retention, it is probable that the implant is permanently joined to the underlying jawbone. A separate surgical procedure for removal of the implant is necessary if implant failure or fracture occurs or requires replacement for changed prosthetic needs. If the implant fails, there will be fees charged for their removal and/or replacement.

No Warranty or Guarantee

I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant will be permanently retained, but because of the uniqueness of every case, and since the practice of dentistry is not an exact science, long-term success cannot be promised.

Consent to Unforeseen Surgical Conditions

During treatment, unknown oral conditions may modify or change the original treatment plan such as discovery of changed prognosis for adjacent teeth or insufficient bone support for the implant. I therefore consent to the performance of such additional or alternative procedures as may be required by proper dental care in the best judgment of the treating doctor.

Patient Agreement to Daily Home Care

In order to improve chances for success, I have been informed that the implant and adjacent teeth must be maintained daily in a clean and hygienic manner, and I agree to perform the home care in accordance with instructions provided, as well as keep periodic professional maintenance visits.

I understand Dr. Moore is a general dentist, and that he will be responsible to assist me during the post-operative phase. It is my responsibility to inform Dr. Moore of any problems that occur following the surgery. I understand how to get in touch with Dr. Moore. In rare cases, it may be necessary to refer some post-operative patients to another doctor. The costs associated with any consultation or treatment with other doctors will be the patient's responsibility.

I certify that I have read and fully understand the above authorization and information consent to implant insertion and surgery and that all of my questions, if any, have been answered.

Date_____ Patient Signature_____

Witness Signature_____

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