Oral Sedation Information and Consent Form

This form is intended to document the discussion we have had regarding your planned oral sedation.

The medication we may be prescribing is either Triazolam (Halcion), Lorazepam (Ativan), Diazepam (Valium) or Midazolam (Versed). This medication can greatly minimize anxiety that may be associated with your upcoming surgery. In a relaxed state, you will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective and wears off rapidly after the dental visit you should be aware of important precautions and considerations.

Benefits of conscious sedation include reduced awareness of unpleasant sights, sounds and sensation associated with dental procedures. Reduced anxiety should also be present.

Risks of conscious sedation include nausea/vomiting, allergy to medication, irritation and/or pain/swelling to skin, breathing problems, brain damage, cardiac arrest and death.

I understand that it is critically important that I fully discuss my complete medical history with the dentist before sedative medications are prescribed.

You should not use these medications if you are pregnant, breast feeding, or have significant liver or kidney disease.

Tell the doctor if you are taking the following medications as they can adversely interact with sedation medications: nafazodone (Serzone); cimetidine (Tagamet, Tagamet HB, Novacimetine, or Peptol); levadopa (Dopar or Larodopa) for Parkinson’s disease; antihistamines (such as benadryll and travist); veraparmil (Calan); dilitaliazem (Cardizem); erythromycin and azole antimycotics (Nizoral, Biaxin, Orporanox; HIV drugs, indiavir and nelfinovir; and alcohol. Of course taking recreational/illicit drugs can also cause untold reactions.

The dentist has reviewed the written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation.

**DO NOT DRIVE AFTER TAKING ORAL SEDATION.**

During the discussion, I have had my questions answered to my satisfaction.

I, ______________________________________________, request and authorize Dr. Nilesh Dalal to administer oral conscious sedation medication and/or nitrous oxide/oxygen conscious sedation to me in conjunction with the planned periodontal procedure.

The reason I am asking for this medication is: _________________________________

Patient/Guardian: ___________________________ Date: __________

Witness: ____________________________________________

Doctor: ____________________________________________
CONSENT TO PERIODONTAL SURGERY

I hereby authorize Dr. Dalal (hereafter called “Doctor”), and whomever he may designate as his assistant(s) to perform upon ____________________________ the following treatment/procedure/surgery.

Mucogingival surgery with/without bone recontouring
Gingivectomy
Scaling and root planning
Extraction of teeth as determined during surgery

Further, I have been informed that other possible alternative methods of treatment include:

Sub-gingival scaling
Scaling and root planning followed by periodic recalls
Maintenance therapy only

If any unforeseen condition should arise in the course of the operation calling for the Doctor’s judgement or for procedures in addition to or different from those now contemplated, I further request and authorize the Doctor to do whatever he may deem advisable.

I have been informed that the purpose of the operation is to surgically treat and possibly correct my periodontally diseased gums and their supporting bone.

Periodontology is not an exact science. No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment. It has been explained to me that the long term success of treatment requires my cooperation and performance of plaque control (home care) at least twice daily, as well as periodic periodontal maintenance visits after the proposed treatment at a dental office.

I further understand that if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth loss, but it may possibly (deteriorate slowly/remain the same) without the proposed treatment.

Risks of the operation include, but are not limited to:

Infection
Pain
Restricted mouth opening for several days or weeks
Gum recession (shrinkage)
Interference with phonetics
Thermal tooth sensitivity
Increased tooth looseness
Food impaction between teeth after eating

I CERTIFY THAT I HAVE READ FULLY AND UNDERSTOOD THE ABOVE CONSENT TO THE OPERATION, THE EXPLANATION THERE IN REFERRED TO OR MADE.

Dated___________________ Signature of Patient__________________________________

Witness________________________
POST OPERATIVE INSTRUCTIONS FOR PERIODONTAL SURGERY

1. **Medications**
   > Medications should be taken with food.
   > Continue taking all prescribed medications UNLESS otherwise advised.
   > Medications for discomfort have been prescribed; take as directed if needed. Do not exceed the recommended dosage.
   > For over the counter anti-inflammatory drugs...take 600-800 mg every 4 hours.

2. **Day One**
   > Apply ice pack to area.
   > Tooth brushing: away from the treated area, normal elsewhere.
   > Diet: soft foods: potatoes, pasta, yogurt, fish, soup, etc.
   > Sleep on two pillows.
   > Rest and relax ~ T.L.C. * No excessive exertion.

   **Avoid:** ☺ For first 24 hours
   > Rinsing with mouthwash/spitting
   > Drinking from a straw
   > Smoking

3. **Day Two**
   > Warm moist compresses if inflammation persists.
   > Rinsing: warm salt water and/or prescribed mouthwash.
   > Continue medications

4. **Day Three**
   > Symptoms may peak: expect some swelling and tenderness.
   > If swelling occurs heat may be applied.

During business hours if questions or concerns arise, you may call our office number 954-341-1000. After hours Dr. Dalal can be reached on his cell phone at 954-649-1212.
CONSENT & PATIENT INFORMATION FOR IMPLANT(S)

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure, I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.

6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

7. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor’s home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

10. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

11. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care if it is felt this is for my best interest.

_________________________                           _______________________
Signature of Doctor                Signature of Patient

If the patient is unable to sign or is a minor
_________________________
(signature of parent or legal guardian)

Witness

_________________________                    __________________________
Date                                                                       Relationship to Patient

The International Congress of Oral Implantologists is a non-profit, international educational organization and is not responsible for the Interpretation, presentation or eventual outcome of the above procedures.
Consent for Extraction

I have recommended that one or more of your teeth be extracted based upon your symptoms, my examination of your mouth, the treatment plan I have discussed with you and your choice. I want you to be aware of the commonly known risks and side effects of this procedure.

They are:
You may experience pain, swelling or bleeding for a time after the extraction. I will give you instructions on how to manage these problems in which, if they occur, should only last for a few days. Of course, should any of these problems be more severe or last longer than you anticipated, call or see me as soon as possible.

You may experience an infection following the extraction. I will advise you to look for any signs of infection. If any of these signs do occur you should call me or see me as soon as possible.

Teeth adjacent to the tooth to be extracted may be chipped of damaged during the extraction.

Nerves which supply sensation to your mouth, chin, lips, tongue and gum tissue may run near the area of the extraction. After the extraction you may experience some alteration of normal nerve sensation (itching, burning or tingling, for example) for a short or indefinite period of time. In some rare instances you may experience a total lack of sensation for a period of time which could be indefinite.

For teeth in the upper arch there is a risk that following the extraction a hole or pathway may be present between the sinus and the oral cavity. This is because the roots of some of the upper teeth and just below the floor of the sinus and sometimes actually go through the sinus floor. If this occurs during the procedure, I may need to make a small surgical repair of the hole and may place you on antibiotics and antihistamines to reduce the risk of a sinus infection.

You may also experience a painful condition known as a dry socket. This occurs when the protective blood clot in the socket where the tooth was removed is dislodged, exposing and irritating nerve endings. This may be caused by failing to closely follow post-op instructions I have given you. Although the condition is temporary and not harmful, it can be readily treated and you should seek treatment from me. I will place my medicine in the socket that will soothe and protect it while alleviating the pain.

I invite your questions concerning the risks discussed and contained in this document. By signing below you acknowledge that you have read this document, understand the information presented and have had all your questions answered satisfactorily.

Name of Patient_______________________ Signature of Patient_________________________

Date_____________________ Witness_________________________

Additional Comments:
POST OPERATIVE INSTRUCTIONS FOR EXTRACTION(S)

1. Medications
   > Medications should be taken with food.
   > **Continue taking all prescribed medications UNLESS otherwise advised.**
   > Medications for discomfort have been prescribed; take as directed if needed. Do not exceed the recommended dosage.
   > For over the counter anti-inflammatory drugs...take 600-800 mg ever 4 hours.

2. 🌸 For the First 24 hours
   > Apply ice pack (frozen peas) to area.
   > **Tooth brushing:** away from surgery area, normal elsewhere.
   > **Diet:** soft foods: potatoes, eggs, yogurt, fish, soup, pasta, etc.
   > Sleep on two pillows.
   > Rest and relax 😔 T.L.C. *No excessive exertion.

   **Avoid: 🌻 For first 24 hours**
   > Warm moist compresses if inflammation persists.
   > Rinsing/spitting
   > Drinking from a straw/carbonated beverages
   > Smoking

3. Day Two
   > Rinsing: Luke warm water and/or salt water.
   > Continue medications.
   > If swelling occurs heat may be applied.

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