tuscany dental centre

2078, 11300 Tuscany Blvd NW
Calgary AB T3L 2V7

Ph: 403-239-0010 **Fax:** 403-239-0011 **Email:** info@tuscanydental.com

ALLODERM TISSUE GRAFT

Pre/Post Operative Instructions

Day of Surgery:

- ☐ For the first 24 hrs post op, ice 10 min on, 10 min off. Not after 24hrs as it will affect healing
- ☐ No activity for remainder of day following appointment & for 24hours later (limit talking, exaggerated mouth movements or facial expressions)
- ☐ **No looking (peeking)** at the site, pulling at your cheek or lips or NO big mouth movements as this could lead to the graft failing.
- ☐ **Do not brush or floss the surgical area until advised by the dentist**
- ☐ Do eat cold & soft foods for the first 24hrs after procedure. After 24hrs, warm soft foods but eat on other side of mouth for 2-3 weeks. Do NOT drink hot liquids.
- ☐ Do not rinse your mouth vigorously
- ☐ Do not drink liquids through a straw
- ☐ Do not smoke or use smokeless tobacco products
- ☐ Do not eat hard, solid foods (peanuts, popcorn, chewing gum, chips etc) for at least two weeks.
- ☐ If swelling or pain increases after 3 days then please contact our office.
- ☐ Apply periosciences AO ProVantage 5x daily with tongue. Use a pea size amount starting evening of surgery & every 3 hrs daily for 1st week, then 3x daily until the sutures are removed
- ☐ Do not exercise for 1 week
- ☐ Do drink plenty of liquids (as long as the previous instructions about liquids are followed)
- ☐ All medications that interfere with clotting such as Aspirin, Vitamin E, fish oils stop for 1 week prior to procedure. Advil and Tylenol are ok to use.
- ☐ No alcohol consumption for 1 week

Swelling:

Swelling and/or bruising may occur.

Telephone Dr. Cam Brauer (403)-804-8719. If you experience any of the following symptoms:

- Fever lasting more than 1 day
- Swelling or pain which begins 3 or more days after surgery
- Difficulty breathing
- Excessive bleeding
- Discomfort not controlled by your prescribed medication
- Anything else that concerns you

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Date: _____

This letter is to request x-rays be released from
Dr. _____

For: _____

_____

_____

Or authorized Dr Cam Brauer and /or Joubin Saffary to forward any requested x-rays

Thank you,

_____

Patient / Parent / Guardian Name

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Intravenous Sedation Authorization

Your proposed dental treatment is to be performed with the use of intravenous sedation. The drugs used are Versed, (midazolam) - same class as valium and Fentanyl is used occasionally. If any problems with these drugs have occurred in the past, it is important that Dr Lovick is informed.

The purpose of IV Sedation is to induce a relaxed, comfortable state for long or difficult dental procedures. The patient **will not** be put to sleep with this procedure, but will be relieved of any anxiety and most recollection of the dental visit will be forgotten.

- Prior to IV Sedation, meals should be restricted to nothing solid consumed for 6 hours nor clear fluid for 2 hours prior to the sedation procedure.
- Wear loose comfortable clothing. Wear short sleeved shirt or long sleeved shirt loose enough to be pushed above the elbow.
- Remove contact lenses prior to the appointment.
- Please do not wear nail polish or lipstick.
- If possible, please arrive at the office at least ten minutes before your scheduled appointment time.
- A BMI (body mass index) of no greater than 34 is permitted to legally proceed with IV sedation at a non-hospital clinic…find yours at www.bmicalculator.org

Most patients are tired and disoriented following sedation; therefore, ALL PATIENTS MUST BE ESCORTED HOME BY A RESPONSIBLE ADULT. THE DRIVER/ESCORT MUST COME TO THE OFFICE to pick up the patient. The **escort must monitor the patient for the first 2hours following surgery in an upright resting position** and call the office if you notice the bleeding is not slowing. Some patients feel normal following sedation, however, UNDER NO CIRCUMSTANCES CAN A PATIENT OPERATE A MOTOR VEHICLE for the rest of the day. In addition, no alcoholic consumption is advised for 18 hours following IV Sedation.

On arriving home, most patients will fall into a normal sleep for several hours and a mild fever may occur. After a good night's sleep, all symptoms will have subsided and normal activities can be resumed.

I have read and understand all of the above information and my BMI is: _____

_____ _____

Signature of Patient or Guardian Date:

_____ _____

Name of Driver Driver's Phone #

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Instructions for Self-Care after Surgery from Tuscany Dental Centre

Rest:

Lying quietly with your head elevated is recommended for the remainder of the day. Always get up slowly from a reclining position. Please keep physical activity to a minimum for 72 hours.

Medication:

As soon as you arrive home, take tablets or capsules prescribed for discomfort even if it does not hurt. Do not take aspirin or any other drug containing aspirin *(such as Anacin, Empirin, Bufferin or APC)* as they can cause bleeding after surgery. If an antibiotic and/ painkiller has been prescribed, please take all the medication as prescribed. **IMMEDIATELY STOP** taking the medication and call us if any drug causes nausea, itching or a skin rash and/ mild to severe stomach upset.

Chlorhexidine Rinse:

Only if given - After surgery, teeth and gums in the affected area should be rinsed with chlorhexidine rinse. Use 1 Tablespoon for 30 seconds. Repeat 2-3 times daily for 1 week. Please do not swallow chlorhexidine rinse and avoid rinsing your mouth vigorously.

Nutrition:

Maintain proper nutrition by choosing soft nutritious food which requires minimum chewing such as homemade milkshakes, smoothies, custards, eggs, cream soups etc. **DO NOT USE A STRAW.** For the first 48 hours avoid hot drinks, hot foods and extremely hard foods.

Stitches:

The sutures or stitches which are around and between your teeth will keep the gum tissues in the correct position for the first 3 days of healing. In most cases the stitches will dissolve and will not require removal in our office. We will inform you if you need them removed.

Swelling:

Swelling often occurs and it is normal. You can help minimize the swelling by placing an ice pack on the area 20minutes on and 20minutes off for the first 2 days. Please do not use heat on your face at all after surgery.

Bleeding:

Some slight seepage of blood is expected after the surgical procedure. Copious bleeding should ***not*** occur. If bleeding, apply pressure with a moistened tea bag to the bleeding area for 20 min and call us.

Smoking:

Heat and smoke can act as an irritant, significantly delaying healing and encouraging bleeding. **Please avoid smoking for 72 hours.**

Alcohol:

Avoid any alcoholic beverages as alcohol can mix with the medications you are taking and cause a severe overreaction. Alcohol also acts as an irritant and may delay the healing process.

Problems:

Please do not hesitate to call Dr. Townsend or Dr. Brauer during the day if some complications occur @ 403-**239-0010** or after hours you can reach **Dr. Brauer @ 403-804-8719** or
Dr. Townsend @ 403-519-0086

tuscany dental centre

2078, 11300 Tuscany Blvd NW
Calgary AB T3L 2V7

Ph: 403-239-0010 **Fax:** 403-239-0011 **Email:** info@tuscanydental.com

Dental Implant Consent Form

Tuscany Dental Centre - Dr Cam Brauer

Patient Name: _____ Date: _____

My Planned procedure will involve placement of (#) _____ implant(s).
*Please initial each paragraph after reading. If you have any questions, please ask your doctor for clarification.

_____ I understand that dental implants are placed in stages. The implant will be placed in the bone and will osseointegrate for 3 months prior to a crown being placed, and up to 6 months if grafting material has been placed.
_____ I understand that there will be an incision made inside my mouth for the purpose of placing one or more dental implants in my jaw to serve as anchors to replace a missing tooth or teeth, upon which an abutment and a crown, bridge, or denture will be secured. I acknowledge that the procedure has been explained to my full understanding, including the number and location of implants and the type of implant that will be used. I understand that at a minimum there will be a charge for the implant, the crown, bridge or denture.
_____ I understand that in certain circumstances, the surgery may involve additional materials and procedures (grafting with bone or artificial bone substitutes, use of healing membranes and associated fixation devices). The need for those procedures may not be apparent until after the surgery has begun. I understand that additional fees may be charged without financial arrangements being made if additional procedures are deemed to be necessary.
_____ Alternative treatment methods such as doing nothing, bridges, or dentures has been explained to me.
_____ I Understand the risks and complications of dental implant surgery include, but are not limited to:

- *Post – operative discomfort and swelling that may require several days of at-home recuperation.
- *Prolonged or heavy bleeding that may require additional treatment.
- * Damage to adjacent teeth or roots of adjacent teeth
- *Post-operative infection that may require additional treatment.
- *Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly
- * Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joint.
- *Numbness, tingling, or pain in the chin, lips, cheeks, gums, tongue including possible loss of taste sensation or teeth on the operated side(s). These symptoms may persist for several weeks or months, and in some cases may be permanent.
- * Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.
- * Bone loss around the implants
- *Implant or prosthesis failure. Rarely, the implant or parts of the structure holding the replacement tooth, or the replacement tooth itself, may fail due to chewing stresses.
- *Rejection of the implant by natural body defenses. (If the implant is lost, it is usually possible to replace it in a later surgery after the bony defect has healed or been bone grafted to achieve adequate bone volume for another implant procedure.

_____ No guarantee can be or has been given that the implant(s) will last for a specific time period. I acknowledge that there is the risk for failure, relapse, selective re-treatment, or worsening of my present condition, despite efforts at optimal care.
_____If you are a smoker there is no guarantee that the implant will integrate.
_____ Maintenance of the implant site as well as continuing hygiene care /interval will be dependent upon the hygienist's recommendation.

My signature below signifies that all questions regarding this consent have been answered to my satisfaction, and I fully understand the risks involved with the proposed procedures and anesthetic. I certify that I read, and understand English. I herby give my consent for the planned surgery.

Signature of Patient or Guardian_____ Date _____

Signature of Dentist _____ Date: _____

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Consent for Gingival Graft

This is my consent for Dr. _____ to perform the following

Procedure _____for Name: _____.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

*My dentist has explained forms of treatment. I have chosen the "AlloDerm" graft - freeze dried acellular dermal graft.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible. Also, if "AlloDerm" is exposed, I understand that I might notice a bad taste or color change of the membrane.

I understand that if I decide not to undertake any treatment, the following complications can occur; worsening of the gingival recession, root cavities, periodontal disease, tooth mobility and sensitivity that may require extraction.

I am aware that ***one week prior to treatment that I will stop taking fish oils / vitamin E supplements.***

I am aware that each patient heals in a different manner after graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

*I understand that smoking, drinking alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and have my graft checked as well as have regular checkups.

To my knowledge, I have given the proper medical information in regards to my physical and mental states (medications, diseases, syndromes, etc. I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin, any abnormal bleeding, or any condition relation to my overall health.

I am aware that there is a non – refundable $500.00 fee for any short notice cancellations. A visa or MasterCard number will need to be provided when scheduling the grafting surgery. The fee will be applied if I fail to provide 24 hours notice or fail to show for my appointment.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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Informed Consent for Endodontic Treatment

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally an unapparent, undiagnosed or hidden problem arises.

The procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had a root canal treatment may require re-treatment, endodontic surgery, or tooth extraction.

RISKS: Are *unlikely,* but may occur. They might include but are not limited to:
*Instrument separation in the canal
*perforations (extra openings) of the canal with instruments.
*Blocked root canals that cannot be ideally completed
*Incomplete healing.
*post-operative infection requiring additional treatment or the use of antibiotics.
*tooth and/or root fracture that may require extraction.
*fracture, chipping, or loosening of existing tooth or crown
*pos-treatment discomfort
*temporary or permanent numbness
*change in the bite or jaw joint difficulty (TMJ problems or TMD)
*medical problems may occur if I do not have the root canal completed
*reactions to anesthetics, chemicals or medications

Other Treatment Choices:

The following other treatment options might be possible:

*no treatment at all
*waiting for more definitive development of symptoms
*extraction: to be replaced with either nothing, a denture, a bridge or an implant

Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture

I have had an opportunity to ask questions of my treatming doctor and I am satisfied with the answers that I have received. I consent to the procedure.

Patient: _____ Tooth#: _____ Date: _____

Patient Signature: _____ Parent / Guardian: _____

Prognosis: _____ Dr: _____Date: _____

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Consent for Gingival Graft

This is my consent for Dr. _____ to perform the following

Procedure _____for Name: _____

The dentist and/or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

*My dentist has explained forms of treatment. I have chosen the "AlloDerm" graft – freeze dried acellular dermal graft.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible. Also, if "AlloDerm" is exposed, I understand that I might notice a bad taste or color change of the membrane. Repositioning of tissues procedure may also be required.

I understand that if I decide not to undertake any treatment, the following complications can occur; worsening of the gingival recession, root cavities, periodontal disease, tooth mobility and sensitivity that may require extraction.

I am aware that **one week prior to treatment that I will stop taking fish oils / vitamin E supplements**.

I am aware that each patient heals in a different manner after graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

*I understand that smoking, drinkin alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and hae my graft checked as well as have regular checkups.

To my knowledge, I have given the proper medical information in regards to my physical and mental states (medications, diseases, syndromes, etc) I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin, any abnormal bleeding, or any condition relation to my overall health.

I am aware that there is a non-refundable $500.00 fee for any short notice cancellations. A visa or mastercard number will need to be provided when scheduling the grafting surgery. The fee will be applied if I fail to provide 24hours notice or fail to show for my appointment.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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Bone Graft Post Surgery Care

Rest:

Always get up slowly from a reclining position. Please keep physical activity to a minimum for 72 hours.

Medication:

As soon as you arrive home, take tablets or capsules prescribed for discomfort even if it does not hurt. Do not take aspirin or any other drug containing aspirin *(such as Anacin, Empirin, Bufferin or APC)* as they can cause bleeding after surgery. If an antibiotic and/ painkiller has been prescribed, please take all the medication as prescribed. **IMMEDIATELY STOP** taking the medication and call us if any drug causes nausea, itching or a skin rash and/ mild to severe stomach upset. **If you have no contraindications take 600mg ibuprofen (advil) every 6hrs alternating with acetaminophen 500-1000mg every 6hrs.**

Pain Management:

Take 600mg ibuprofen (Advil) every 6 hours as needed alternating with 500-1000 mg Acetaminophen (Tylenol) every 6hrs as needed

Example: 9am Advil, Noon Tylenol, 3pm Advil, 6pm Tylenol, 9pm Advil

Chlorhexidine Rinse:

Only if given - After surgery, teeth and gums in the affected area should be rinsed with chlorhexidine rinse. Use 1 Tablespoon for 30 seconds. Repeat 2-3 times daily for 1 month. Please do not swallow chlorhexidine rinse and avoid rinsing your mouth vigorously.

Nutrition:

Maintain proper nutrition by choosing soft nutritious food which requires minimum chewing such as homemade milkshakes, smoothies, custards, eggs, cream soups etc. For the first 48 hours avoid hot drinks, hot foods and extremely hard foods.

Stitches:

NO PEEKING: The sutures or stitches which are around and between your teeth will keep the gum tissues in the correct position. You will be scheduled to remove them

Bleeding:

Some slight seepage of blood is expected after the surgical procedure. Copious bleeding should ***not*** occur.

Smoking:

No smoking or the graft will fail.

Alcohol:

Avoid any alcoholic beverages as alcohol can mix with the medications you are taking and cause a severe overreaction. Alcohol also acts as an irritant and may delay the healing process.

Problems:

Please do not hesitate to call Dr. Brauer during the day if some complications occur @ 403-**239-0010** or after hours you can reach
Dr. Brauer @ 403-804-8719

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Extractions (removal) of Baby Teeth

Why do baby teeth need to be removed?
When a tooth has been damaged either by infection (from tooth decay or gum disease) or trauma (from a knock or bump) or as requested by your orthodontist.

How is the baby tooth removed?
The tooth and surrounding area will be numbed by local anesthetic. Once the area is numb the tooth is removed. Your child will be asked to bite down on a piece of gauze to help stop the bleeding and form a clot.

What are the risks of removing a baby tooth?
Damage to lips and cheeks: child may bite or rub the numbed area without realising the damage it may be causing; children may need to be supervised until the numbness has worn off
Short term minimal to moderate pain is anticipated and can be remedied by an anti-inflammatory (like Advil based on Dr recommendation)

Uncommon risks and complications include:
If a baby tooth is lost early, the adult tooth may not be ready to move into position to fill the space; this can result in a loss of space for the adult tooth
Irritation to the nerves during the extraction can cause permanent or prolonged numbness or tingling sensation to the lip, tongue, cheek, chin, gums or teeth

What happens following removal of my child's tooth?
Healing usually occurs quickly without complications
Following removal of the tooth, the anesthetic effect may continue for some hours. Your child's mouth may feel swollen and uncomfortable during this period. Some pain can be expected because the tissues have been disturbed during the tooth removal.

What can I / my child do to help prevent complications following removal of a tooth?
Avoid eating until the numbness is gone
Your child must not bite or suck the lip, cheek or tongue while the area is numb
Chew food on the opposite side of the mouth to the wound for 24hours.
I have had the opportunity to ask questions of my doctor and I consent to the procedure.

_____ _____

Parent / Guardian / Patient Date

_____ _____

Printed Name if signed on behalf of patient Relationship

_____ _____

Doctor Signature (Dr Cam Brauer / Dr Joubin (Jay) Saffary) Date

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Ph: 403-239-0010 **Fax:** 403-239-0011 **Email:** info@tuscanydental.com

Dental Implant Consent Form

Tuscany Dental Centre - Dr Cam Brauer

Patient Name: _____ Date: _____

My Planned procedure will involve placement of (#) _____ implant(s).
*Please initial each paragraph after reading. If you have any questions, please ask your doctor for clarification.

_____ I understand that dental implants are placed in stages. The implant will be placed in the bone and will osseointegrate for 3 months prior to a crown being placed, and up to 6 months if grafting material has been placed.
_____ I understand that there will be an incision made inside my mouth for the purpose of placing one or more dental implants in my jaw to serve as anchors to replace a missing tooth or teeth, upon which an abutment and a crown, bridge, or denture will be secured. I acknowledge that the procedure has been explained to my full understanding, including the number and location of implants and the type of implant that will be used. I understand that at a minimum there will be a charge for the implant, the crown, bridge or denture.
_____ I understand that in certain circumstances, the surgery may involve additional materials and procedures (grafting with bone or artificial bone substitutes, use of healing membranes and associated fixation devices). The need for those procedures may not be apparent until after the surgery has begun. I understand that additional fees may be charged without financial arrangements being made if additional procedures are deemed to be necessary.
_____ Alternative treatment methods such as doing nothing, bridges, or dentures has been explained to me.
_____ I Understand the risks and complications of dental implant surgery include, but are not limited to:

*Post – operative discomfort and swelling that may require several days of at-home recuperation.
*Prolonged or heavy bleeding that may require additional treatment.
* Damage to adjacent teeth or roots of adjacent teeth
*Post-operative infection that may require additional treatment.
*Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly
* Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joint.
*Numbness, tingling, or pain in the chin, lips, cheeks, gums, tongue including possible loss of taste sensation or teeth on the operated side(s). These symptoms may persist for several weeks or months, and in some cases may be permanent.
* Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.
* Bone loss around the implants
*Implant or prosthesis failure. Rarely, the implant or parts of the structure holding the replacement tooth, or the replacement tooth itself, may fail due to chewing stresses.
*Rejection of the implant by natural body defenses. (If the implant is lost, it is usually possible to replace it in a later surgery after the bony defect has healed or been bone grafted to achieve adequate bone volume for another implant procedure.

_____ No guarantee can be or has been given that the implant(s) will last for a specific time period. I acknowledge that there is the risk for failure, relapse, selective re-treatment, or worsening of my present condition, despite efforts at optimal care.
_____If you are a smoker there is no guarantee that the implant will integrate.
_____ Maintenance of the implant site as well as continuing hygiene care /interval will be dependent upon the hygienist's recommendation.

My signature below signifies that all questions regarding this consent have been answered to my satisfaction, and I fully understand the risks involved with the proposed procedures and anesthetic. I certify that I read, and understand English. I herby give my consent for the planned surgery.

Signature of Patient or Guardian_____ Date _____

Signature of Dentist _____ Date: _____

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2078, 11300 Tuscany Blvd NW
Calgary AB T3L 2V7
Ph# 403-239-0010
Fax: 403-239-0011
Email: info@tuscanydental.com

Date: _____

This letter is to request x-rays be released from
Dr. _____

For: _____

_____

_____

Or authorized Dr Cam Brauer and /or Joubin Saffary to forward any requested x-rays

Thank you,

_____

Patient / Parent / Guardian Name

tuscany dental centre

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Ph: 403-239-0010 **Fax:** 403-239-0011 **Email:** info@tuscanydental.com

Oral Surgery Consent Form

Dr Cam Brauer DMD &/or Dr Joubin (Jay) Saffary DDS

This is my consent for Dr. _____ and any associates to perform the following

Procedure _____for Name: _____.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

The doctor has ***explained*** to me that there are certain potential risks in the treatment plan or procedure. These include:

- Injury to Nerve resulting in numbness or tingling of the chin, lips, cheek, gums and or tongue to the side being treated. This may persist for several weeks, months, or in remote instances, permanently. _____(initial)
- Post operative infection requiring additional treatment.
- Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced or the tooth itself can dislodge into the sinus or an opening may occur into the mouth, which may require additional care.
- Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular joint.
- Injury to adjacent teeth and/or fillings.
- In rare circumstances, medical situation requiring medical personnel and or ambulance can occur.
- Post operative discomfort, swelling, and bleeding that may necessitate several days of recuperation
- Decision to leave a small piece of root in the jaw when it's removal requires extensive surgery or complication.
- Stretching of the corners of the mouth with resultant cracking and bruising
- For patients who receive IV Sedation it is required that they **do not consume food 6 hours prior** to treatment or **beverages 2 hours prior** to treatment. You must rest in an upright position following surgery.

To my knowledge, I have given an accurate report of my health history.

Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can cause additional side effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

I have also been advised not to smoke for two weeks after the surgery _____

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

_____ _____

Patient Signature / Guardian (if under 18 years of age) (Print name then sign please) Date

_____ _____

Doctor Signature Date

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Ph: 403-239-0010 **Fax:** 403-239-0011 **Email:** info@tuscanydental.com

Bone Graft Consent

This is my consent for Dr. _____ to perform the following

Procedure _____for Name: _____.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

*My dentist has explained forms of treatment. I have chosen the bone graft to provide stability for future treatment.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible.

I am aware that each patient heals in a different manner after bone graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

I understand that smoking, drinking alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and have my bone graft checked as well as have regular checkups and hygiene.

To my knowledge, I have given the proper medical information in regards to my physical and mental states (medications, diseases, syndromes, etc). I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin , any abnormal bleeding, or any condition related to my overall health.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____