DAVID L. ROBERTS, DDS, PA
— General Dentist Providing Oral Surgery Services —
_____ (ofc) 972.404.1911 (home) dave@robertsdds.com www.robertsdds.com

PRE-OPERATIVE INSTRUCTIONS FOR DENTAL ANESTHESIA/SURGERY

**** VERY IMPORTANT INFORMATION—PLEASE READ CAREFULLY. ****

****COMPLETE & RETURN ATTACHED "MEDICAL HISTORY UPDATE FORM" (2 OF 10)****

1. If you have any concerns or questions about the surgery, please contact Dr. Roberts at 972/404-1911 or by email at dave@robertsdds.com.
2. He will be reviewing your medical history with you immediately prior to the surgery. Please be sure you are familiar with the name(s) and dosage(s) of any medications you are taking. **If your history is complicated, he will need to consult with your physician before the procedure is performed. Any unaddressed items on your medical history may cause your surgery to be delayed or canceled. A copy of this MD consultation form can be found on page 3 of 10 or on Dr. Roberts's website at www.robertsdds.com.**
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 Forms."
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) moderate sedation:

1. **Do not eat or drink anything (including water) for *at least six hours prior to your appointment*.**
   - **Avoid fatty foods for at least eight hours prior to surgery.**
   - 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, which 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 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 moderate sedation. If you have any questions about the IV moderate sedation process, please feel free to contact Dr. Roberts at 972/404-1911, or by email at dave@robertsdds.com, prior to the procedure.

NOTE: Additional pre-operative information can be found at *www.robertsdds.com*. Please preview the "Disclosure and Consent Form" and view all post-op videos on the website prior to your surgery. Copies of forms may also be requested from your dentist.

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MEDICAL HISTORY UPDATE FORM

Date_____

Name_____ Dentist's Name:_____
Last First Middle

Social Security #_____ Ht_____ Wt_____ Date of Birth_____

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

For the questions below, circle yes or no. Your answers are for our records only and will be considered confidential. You will be asked some questions about your responses, and there may be additional questions concerning your health. In some cases, a consultation with your MD may be required before the surgery can be performed safely without a delay or postponement.

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. Roberts Signature of Patient (or Patient's Guardian)

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

NOTE: If your medical history is complicated, we may need to consult with your MD prior to your appointment. This consultation form may be found on page 3 of 10 or at www.robertsdds.com. Contact Dr. Roberts directly with any questions.

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Medical Consultation & Physician Report for Dental Surgery

Dear _____, MD: Date of Request:_____

Our mutual patient, _____, is planning to have dental surgery with local anesthesia and possibly with IV moderate sedation. **Potential intra-operative medications include:** Valium, Versed, Fentanyl, Ondansetron, Dexamethasone, Lidocaine with Epinephrine, Marcaine with Epinephrine, and Nitrous Oxide. **Potential post-operative medications include:** Norco, Penicillin, Ondansetron, Peridex, Cleocin, Ibuprofen, Naproxen, 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 # 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 ☐ NO

_____

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 972.404.8557 or to _____. If you have any questions regarding the above, please call Dr. David Roberts at 972.404.1911. Thank you.

Sincerely,

David L. Roberts, DDS, PA, working with _____, DDS

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DISCLOSURE & CONSENT—DENTAL & 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 David L. Roberts, D.D.S., P.A. and such associates, technical assistants, and other healthcare 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 healthcare 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. Roberts 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. Roberts 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. Roberts from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Roberts is a General Dentist.

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 moderate sedation ("twilight sleep") and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV moderate 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 moderate 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, cardiac arrest, 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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NERVE INJURY 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. Roberts	Date Signed

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POST-OPERATIVE INSTRUCTIONS FOLLOWING DENTAL ANESTHESIA/ SURGERY

****The best post-op instructions are on our website (www.robertsdds.com). Watch all 7 post-op videos.****

THINGS TO EXPECT:

Bleeding: Mild bleeding or "oozing" is normal for the first 12-24 hours following surgery (see Chapter 1 Video).

Swelling: Swelling is normal following a surgical procedure. It should reach its maximum on post-op day 4 and should begin to diminish by the sixth post-op day, gradually decreasing each day thereafter (see Chapter 2 Video).

Discomfort: Significant discomfort may occur for a few hours after the sensation returns to your mouth. It may gradually increase again on post-op days 2, 3, and 4 but should begin to diminish on day 6 and on each day thereafter.

THINGS TO DO IMMEDIATELY FOLLOWING SURGERY:

Bleeding: Place gauze over extraction sites and maintain pressure by biting until the bleeding has stopped. Repeat as needed. Keep head elevated, and rest. Do not suck or spit excessively. Also, please refrain from blowing into musical instruments. Do not sleep with gauze in your mouth (see Chapter 1 Video).
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 10 minutes every half-hour for the first 8-12 hrs.
NOTE: Ice bags or cold compresses should be used only on the day of surgery (see Chapter 3 Video).

Smoking: Avoid smoking for several weeks during the healing period, as smoking will make the pain much worse and will increase all post-op problems.

Discomfort: Most post-op pain can be relieved by taking non-prescription doses of Advil or Aleve, PLUS extra-strength Tylenol, every 4-6 hours for several days. Some patients may take intermittent doses of the prescription pain medication, but it should be used sparingly due to the side effects of the medication. 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 diet, or a diet of foods that easily dissolve, will be ideal 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. The number one reason for increased pain and swelling is having food stuck in the sockets (see Chapter 7 Video).

Physical Activity: For the first 24-48 hours, one should REST. Patients who have had sedation or who are taking the prescription pain medication 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, and keep extraction site(s) CLEAN and free of food debris until holes close (in 3-6 weeks).
2. Beginning 24 hours after the surgery, rinse mouth with *WARM SALT WATER* (or prescription mouth rinse). Continue rinsing 2-3 times per day for 7 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* (unless you are experiencing any adverse side effects), in which case you should contact Dr. Roberts (email contact is preferred).
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. A *DRY SOCKET* is a delayed healing response that is most likely caused by food debris in the socket, by smoking, or by not taking pain medications as directed. Dry sockets may occur during the second-to-fourth post-operative day. They are 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. Roberts (see Chapter 6 Video).
7. **RETURN TO YOUR DENTIST'S OFFICE** 5-7 days after the surgery for irrigation instructions.
8. Additional post-operative information can be found at *www.robertsdds.com* (see Chapter 4 Video).

CONTACT THE DOCTOR IF: (See Chapter 5 Video)

1. Bleeding is excessive and cannot be controlled.
2. Discomfort is poorly controlled (see Chapter 3 Video).
3. Swelling is causing any difficulty breathing or swallowing or if swelling is excessive, spreading, or continuing to enlarge after 60 hours. The swelling should start to improve after the end of day 5.
4. Allergic reactions to medications occur, which are causing a generalized rash or excessive itching.

Call 911 immediately if the patient has trouble breathing, becomes unresponsive, or is difficult to awaken. After calling 911, call Dr. Roberts at 972.404.1911 ASAP.

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of David L. Roberts, 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 David L. Roberts, 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